Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

- •Added Healthcare for Workers with Disabilities as an eligibility group
- •Caregiver/Recipient Training Service new providers:
 - -Behavior Intervention Specialist
 - -Chronic Disease Self management Trainer
 - -Pharmacist
 - -Community Mental Health Agency
 - -Center for Independent Living
- •Used current CMS definition of Community Transition Services

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State** of **Washington** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- **B.** Program Title (optional this title will be used to locate this waiver in the finder): COPES renewal 2009
- C. Type of Request: renewal

Effective Date: (mm/dd/yy)

	Migration Waiver - this is an existing approved waiver				
V	Renewal of Waiver:				
	Provide the information about the original waiver being renewed				
	Base Waiver Number: 0049				
	Amendment Number				
	(if applicable):				

04/01/09

	Waiver Number: WA.0049.R06.00 Draft ID: WA.03.06.00
	Renewal Number: 06
D.	Type of Waiver (select only one):
υ.	Regular Waiver
Ε.	Proposed Effective Date: (mm/dd/yy)
	04/01/09
	Approved Effective Date: 04/01/09
1. R	equest Information (2 of 3)
F.	Level(s) of Care . This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (<i>check each that applies</i>): Hospital
	Select applicable level of care
	• Hospital as defined in 42 CFR §440.10 If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level
	of care:
	☐ Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160 ☐ Nursing Facility
	Select applicable level of care
	Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155
	If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	☐ Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42
	CFR §440.140
	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)
	If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:
1. Re	equest Information (3 of 3)
G.	Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities Select one:
	Not applicable
	Applicable Check the applicable authority or authorities:
	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
	Waiver(s) authorized under §1915(b) of the Act.
	Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
	Specify the §1915(b) authorities under which this program operates (check each that applies): [§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)
§1915(b)(3) (employ cost savings to furnish additional services)
§1915(b)(4) (selective contracting/limit number of providers)
A program operated under §1932(a) of the Act.
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
A program authorized under §1915(i) of the Act.
A program authorized under §1915(j) of the Act.
A program authorized under §1115 of the Act.
Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods. The Community Options Program Entry System (COPES)provides home and commnity-based services targeted to aged and disabled individuals who are at nursing facility level of care. This waiver is for individuals who receive waiver services in their homes or in a residential facility such as an Adult Family Home or Boarding Home.

The waiver is administered by the State Department of Social and Health Services (DSHS) through the Aging and Disabilities Services Administraton (ADSA). The State determines initial financial and functional eligibility for services. Ongoing residential case management is provided by ADSA local Home and Community Services offices, and inhome case management is provided by local Area Agencies on Aging (AAA).

The goal of this waiver is to support participants in their own homes or in residential facilities rather than in a nursing facility or other more restrictive settings. The objective of the waiver is to develop and implement supports and services to successfully maintain individuals in their homes and communities. Each applicant participates in completing an individual assessment and developing a written plan of care that is tailored to meet their individual needs. The waiver includes the following services:

- Personal Care
- Personal Emergency Response System (PERS)
- Environmental Modifications
- Skilled Nursing
- Transportation
- Home Health Aide Services
- Adult Day Care
- Caregiver/Recipient Training Services
- Home Delivered Meals
- Specialized Medical Eqipment
- Nurse Delegation
- Community Transition Services

Individuals may chose to self direct their personal care.

The waiver serves over 30,000 individuals (unduplicated yearly count) who meet financial and functional criteria. More information on the waiver and other aging and disability services in Washington State can be found at: http://www.adsa.dshs.wa.gov.

3. Components of the Waiver Request

The waiver application consists of the following components. Note: Item 3-E must be completed.

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

- **B.** Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- **D.** Participant-Centered Service Planning and Delivery. Appendix **D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- **E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
 - **Yes.** This waiver provides participant direction opportunities. *Appendix E is required.*
 - No. This waiver does not provide participant direction opportunities. Appendix E is not required.
- **F.** Participant Rights. Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- **G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- **B.** Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (select one):
 - Not Applicable
 - No
 - Yes
- **C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
 - No
 - Yes

If yes, specify the waiver of statewideness that is requested (check each that applies):

- Geographic Limitation. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
 - Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
- **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to

e in
areas
service
vaiver
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5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- **A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
 - 1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 - 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 - Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services
 are provided comply with the applicable State standards for board and care facilities as specified in Appendix
 C.
- **B.** Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.
- **D.** Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
 - 1. Informed of any feasible alternatives under the waiver; and,
 - 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.
- **F.** Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s)

specified for this waiver.

- **G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- **H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- **I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- **J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in Appendix D. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- **B.** Inpatients. In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- **D.** Access to Services. The State does not limit or restrict participant access to waiver services except as provided in Appendix C.
- **E.** Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- **G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- **H. Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input. Describe how the State secures public input into the development of the waiver:

 In preparation for renewal of the (COPES) Waiver, input about COPES services was obtained from individuals from all areas of Washington State who have a vested interest in the services provided by this waiver. Outreach was made to Tribes, individuals using services provided through the waiver, service providers, advocates, and Aging and Disability Services (ADSA) and Area Agencies on Aging (AAA) case management staff.

Input on COPES services was primarily gathered through focused group discussions facilitated by ADSA staff. Input was collected from 292 participants attending a total of 16 meetings between May 8 and August 21, 2008.

In addition to focused discussions, input was also collected through written responses to a short survey. This survey was distributed by email as a follow up to participants in focused group discussions and was in turn distributed by them to other members of their respective organizations. The survey was mailed directly to 29 Tribal Chairpersons in Washington State and to 200 individuals enrolled in the COPES Waiver. In total, 61 survey responses were received.

Results of this input have been incorportated into the renewal application.

The State routinely secures public input by working closely with the following:

- State Legislature
- Other divisions and state agencies, (Mental Health, Alcohol and Substance Abuse, Vocational Rehabilitation, Department of Health, Medical)

The Medicaid Agency meets regularly with the following to share information and obtain input on program design and quality of care:

- State Quality Assurance Advisory Committee which includes family members, clients, providers, and other stakeholders
- County Coordinators for Human Services
- The Washington Association of Area Agencies on Aging
- Provider associations: Home Care, Home Health, Nursing Facility
- Boarding Home and Adult Family Home Advisory Boards
- Goveror's Disability Council
- Senior Lobby
- Senior Council on Aging (Governor's Committee)
- Older Adults Advisory Committee (Mental Health)
- Northwest Justice Project
- Quarterly Case Management Meetings

Input on waiver development is also obtained from participant satisfaction surveys.

The State maintains a government to government relationship with the federally recognized Tribes in the state. This includes written accords, a formal process for consultation and process for informal input.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available

through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

8. Authorizing Signature

Last Name:	Marilee		
First Name:	Fosbre		
Title:	HCBS Waiver Manager		
Agency:	Aging and Disability Service	es Administration	
Address:	P.O. Box 45600		
Address 2:			
City:	Olympia		
State:	Washington		
Zip:	98504-5600		
Phone:	(360) 725-2536	Ext: TTY	
Fax:	(360) 438-8633		
Fax: E-mail:	(360) 438-8633 fosbrma@dshs.wa.gov		
E-mail:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name: Title:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name: Title: Agency:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name: Title: Agency: Address:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name: Title: Agency: Address: Address 2:	fosbrma@dshs.wa.gov	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name: Title: Agency: Address: Address 2: City:	fosbrma@dshs.wa.gov he State operating agency repres	entative with whom CMS should communicate regardi	ng the wai
E-mail: If applicable, t Last Name: First Name: Title: Agency: Address: Address 2: City: State:	fosbrma@dshs.wa.gov he State operating agency repres	entative with whom CMS should communicate regardi	ng the wair
E-mail: If applicable, t Last Name: First Name: Title: Agency: Address: Address 2: City: State: Zip:	fosbrma@dshs.wa.gov he State operating agency repres		ng the wai

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:	Kathy Leitch	
	State Medicaid Director or Designee	
Submission Date:	Feb 27, 2009	
Last Name:	Marshburn	
First Name:	Stan	
Title:	Interim Secretary	
Agency:	Department of Social and Health Services	
Address:	P.O. Box 45010	
Address 2:		
City:	Olympia	
State:	Washington	
Zip:	98504-5010	
Phone:	(360) 902-7800	
Fax:	(360) 902-7848	
E-mail:	marshsb@dshs.wa.gov	
Attachment #1	1: Transition Plan	
Specify the transition	on plan for the waiver:	
NA		
Additional Ne	eded Information (Optional)	
Provide additional r	needed information for the waiver (optional):	
Appendix A: V	Waiver Administration and Oper	ration

- 1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):
 - The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):

The Medical Assistance Unit.

Specify the unit name:

(Do not complete item A-2)

Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

Aging and Disability Services Administration (Complete item 4-2-a).

The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
The COPES waiver is administered by the Department of Social and Health Services (DSHS), the Single State Medicaid Agency in Washington State. The Secretary of DSHS is signatory for all aspects of waiver operation including waiver applications, amendments, 372 reports and all other CMS communications. The mechanics of submitting CMS web-based waiver reports and applications have been delegated to the Assistant Secretary for Aging and Disability Services (ADSA)subsequent to the Secretary's approval. The Assistant Secretary for ADSA reports directly to the Secretary of DSHS.

A copy of the DSHS organizational chart is available to CMS.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3.	Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative
	functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (select one):

\bigcirc	Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).		
	Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5		
	and A-6.:		

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

- **4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):
 - Not applicable
 - **Applicable** Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
 - Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

The Medicaid agency contracts with 13 Area Agencies on Aging (AAAs) to perform certain operational and administrative functions at the local level. AAAs are single or multi-county entities. Two AAAs are operated by tribes (Colville Indian AAA and Yakama Nation AAA). In all cases, the Medicaid agency has a contract that sets forth the responsibilities and performance requirements of the AAA. The contract is available through the Medicaid agency.

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Department of Social and Health Services
Aging and Disability Services Administration

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Performance assessment and oversight of non-state entities is performed by the Medicaid agency (ADSA)with methods and frequency as follows:

AAA billings are reviewed on a monthly basis by ADSA fiscal staff and the assigned ADSA AAA Specialist. This includes monitoring expenditures against contract balances, ensuring that billed services are in accordance with the AAA's approved Area Plan, etc. ADSA also monitors monthly to ensure that required staffing ratios are maintained for case management, nursing, and supervisory positions.

ADSA Quality Assurance Specialists (QAS) perform a variety of monitoring activities each review cycle. A review cycle is 18 months. The focus of each review cycle is determined by an analysis of the previous years monitoring results to ensure remediation and improvement. Reviews also focus on ensuring that the CMS protocols are addressed and Washington is in compliance with state and federal regulations. During the 2006-2007 review cycles, QAS staff performed desk compliance audits of 6% of the active regional/AAA clients. The sample size is determined based on accepted statistical sampling methods.

Each QA monitoring cycle includes a review of the information that is disseminated to potential waiver enrollees as well as training materials for staff. Level of care evaluations are reviewed for accuracy and eligibility. Subcontracts are reviewed to ensure that services outlined in the contract are delivered by qualified providers to recipients as outlined in their plan of care. The State Unit on Aging (SUA) which is responsible for AAA contract management participates in each QAS monitoring cycle including being on site for the QAS entrance/exit conferences and approval of Corrective Action Plans.

In addition to QA monitoring, ADSA completes on site contract and fiscal monitoring every two years. In years when there is not a full review, desk reviews and follow-up on corrective actions are completed on a defined schedule. Monitoring includes whether providers are qualified, that payments are accurate, that authorized services address current needs and that informal supports are reflected. ADSA also monitors the remaining AAA programs based on a risk assessment tool.

ADSA follows the requirements of the Single Audit Act and OMB CIRCULAR A-133 in determining audit requirements for AAAs and sub-contractors.

The State Auditor's Office performs yearly audits of County-based AAAs. AAAs that are not a division of county government are audited annually by a certified public accounting firm.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	✓	
Waiver enrollment managed against approved limits	✓	

Waiver expenditures managed against approved levels	∀	
Level of care evaluation	✓	<u> </u>
Review of Participant service plans	▽	V
Prior authorization of waiver services	✓	>
Utilization management	✓	
Qualified provider enrollment	✓	>
Execution of Medicaid provider agreements	✓	V
Establishment of a statewide rate methodology	▽	
Rules, policies, procedures and information development governing the waiver program	V	
Quality assurance and quality improvement activities	▽	V

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of waiver participants who received a redetermination of LOC by the AAA within annual timeframe N=All waiver participants reviewed who received a timely annual redetermination of LOC by AAA D= All waiver participants reviewed

Data Source (Select one): Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	☐ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review

Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 18 months	

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

Performance Measure:

Percent of service plan completed by AAA for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means N=Number of service plans completed by AAA reviewed that address all assessed needs and personal goals D=Number of service plans completed by AAA reviewed

Data Source (Select one): **Record reviews, off-site** If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	☐ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review

Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 18 months	

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

Performance Measure:

Percent of waiver participants whose POC was reviewed and updated by the AAA within annual timeframe N=All waiver participants reviewed whose POC was reviewed and updated by the AAA within annual timeframe D= All AAA waiver participants reviewed

Data Source (Select one): **Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	☐ 100% Review
Operating Agency	 Monthly	Less than 100% Review

Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 18 months	

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	▽ Other

Performance Measure:

Percent of records reviewed where services identified in the POC are authorized N=Number of AAA records reviewed where all services identified in the POC are authorized D=Number of AAA records where the POC identifies services

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	☐ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review
Sub-State Entity	☐ Quarterly	Representative

		Sample Confidence Interval = 5%
Other	☐ Annually	Stratified
Specify:		Describe Group:
	Continuously and	☐ Other
	Ongoing	Specify:
	 ✓ Other	
	Specify: 18 months	

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	□ Weekly
☐ Operating Agency	 ■ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	☐ Continuously and Ongoing
	Other Specify: 18 months

Performance Measure:

Percent of correct AAA waiver service authorizations Numerator: Number of correct AAA waiver service authorizations reviewed Denominator: Number of AAA waiver service authorizations reviewed

Data Source (Select one): **Record reviews, off-site** If 'Other' is selected, specify:

Responsible Party for Frequency of data Sampling Approach(check data collection/generation collection/generation each that applies): (check each that applies): (check each that applies): **▼** State Medicaid ■ Weekly **■ 100% Review** Agency **☐** Operating Agency **Monthly** Less than 100% Review **■** Sub-State Entity Quarterly **Representative** Sample Confidence

		Interval = 5%
Other Specify:	☐ Annually	Describe Group:
	Continuously and Ongoing	Other Specify:
	Specify: 18 months	

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	 ☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

Performance Measure:

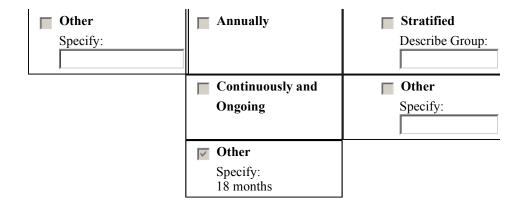
The percent of providers determined by AAA to meet qualifications prior to service authorization N=Number of providers reviewed that AAA determined met provider qualifications D=Number of providers reviewed that AAA contracted

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	™ Weekly	☐ 100% Review
☐ Operating Agency	 ■ Monthly	Less than 100% Review
Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval = 5%



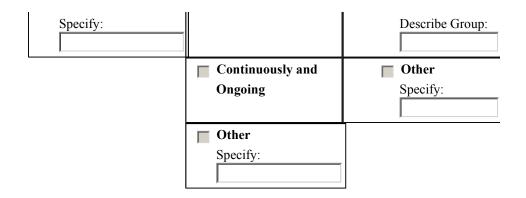
Data Aggregation and Analysis:				
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):			
▼ State Medicaid Agency	□ Weekly			
☐ Operating Agency	 ☐ Monthly			
☐ Sub-State Entity	☐ Quarterly			
Other Specify:	☐ Annually			
	Continuously and Ongoing			
	Other Specify: 18 months			

Performance Measure:

Percent of Area Agencies on Aging (AAA) reviewed that correctly executed Medicaid provider agreements N: Number of AAAs reviewed that correctly executed Medicaid provider agreements D: Number of AAAs reviewed

Data Source (Select one): Record reviews, off-site

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	☐ Weekly	№ 100% Review
☐ Operating Agency	☐ Monthly	Less than 100% Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
		+



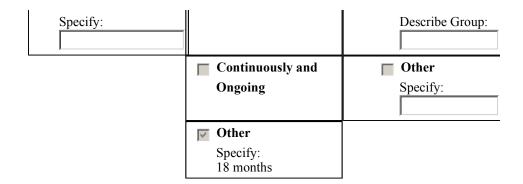
Data Aggregation and Analysis:				
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):			
State Medicaid Agency	☐ Weekly			
☐ Operating Agency	☐ Monthly			
☐ Sub-State Entity	☐ Quarterly			
Other Specify:	✓ Annually			
	☐ Continuously and Ongoing			
	Other Specify:			

Performance Measure:

Percent of AAAs that monitor four participant records per case manager per year N: Number of AAAs that monitor four participant records per case manager per year D: **Number of AAAs**

Data Source (Select one): Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	№ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review
□ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
	P	}



Data Aggregation and Analysis:				
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):			
State Medicaid Agency	□ Weekly			
☐ Operating Agency	 			
☐ Sub-State Entity	☐ Quarterly			
Other Specify:	☐ Annually			
	Continuously and Ongoing			
	Other Specify: 18 months			

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

QA and fiscal corrective actions plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans are evaluated and individualized prior to approval to ensure that plan will effectively address areas of needed improvement. AAAs are required to perform discovery and remediation activities. Training elements of corrective action plans are coordinated through DSHS and DSHS staff is made available to provide training and technical support to AAA staff. AAAs are required to provide QA with an update at six months to report on their progress toward implementing corrective actions.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

QA and fiscal corrective actions plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans include how individual problems are corrected as they are discovered. Some issues, such as health and safety, require immediate action. Corrective action plans are evaluated and individualized prior to approval to ensure that plan will effectively address areas of needed improvement. Training elements of corrective action plans are coordinated through DSHS and DSHS staff is made available to provide training and technical support to AAA staff. AAAs are required to provide QA with an update at six months to report on their progress toward implementing corrective actions.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that Frequency of data aggregation and

applies):	analysis (check each that applies):
State Medicaid Agency	™ Weekly
☐ Operating Agency	™ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
,	Continuously and Ongoing
	Other Specify: 6 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No
 No
 ■ No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:

				Maxim	um Age	
Target Group	Included	Target SubGroup	Minimum Age	Maximum Age Limit	No Maximum Age Limit	
Aged or Disa	bled, or Both - Ge	neral				
	✓	Aged	65		✓	
	✓	Disabled (Physical)	18	64		
	<u> </u>	Disabled (Other)	18	64		
Aged or Disa	Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury				
		HIV/AIDS				
		Medically Fragile				
		Technology Dependent				
Mental Retardation or Developmental Disability, or Both						
		Autism				

		Developmental Disability		
		Mental Retardation		
Mental Illnes	S			
		Mental Illness		
		Serious Emotional Disturbance		

b. Additional Criteria. The State further specifies its target group(s) as follows:

Persons with disabilities may continue to participate in the waiver beyond age 64 specified in the chart.

- **c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):
 - Not applicable. There is no maximum age limit
 - The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

The waiver does not have maximum age limits. Persons with disabilities may continue to participate in the waiver beyond age 64 specified in the chart.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- **a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
 - No Cost Limit. The State does not apply an individual cost limit. Do not complete Item B-2-b or item B-2-c.
 - Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. Complete Items B-2-b and B-2-c.

The limit specified by the State is (select one)

■ A level higher than 100% of the institutional average.		
Specify the percentage:		
• Other		
Specify:		

• Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based

services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. Complete Items B-2-b and B-2-c. Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c. The cost limit specified by the State is (select one): • The following dollar amount: Specify dollar amount: The dollar amount (select one) • Is adjusted each year that the waiver is in effect by applying the following formula: Specify the formula: May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount. • The following percentage that is less than 100% of the institutional average: Specify percent: Other: Specify: **Appendix B: Participant Access and Eligibility B-2:** Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:
- c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an

follo	unt that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the owing safeguards to avoid an adverse impact on the participant (check each that applies): The participant is referred to another waiver that can accommodate the individual's needs.
	Additional services in excess of the individual cost limit may be authorized.
	Specify the procedures for authorizing additional services, including the amount that may be authorized:
	Other safeguard(s)
	Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	32488
Year 2	32943
Year 3	33404
Year 4 (renewal only)	33872
Year 5 (renewal only)	34346

- **b.** Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (select one):
 - The State does not limit the number of participants that it serves at any point in time during a waiver year.
 - The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	

Year 5 (renewal only)

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- **c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (select one):
 - Not applicable. The state does not reserve capacity.
 - The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- **d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
 - The waiver is not subject to a phase-in or a phase-out schedule.
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.
- e. Allocation of Waiver Capacity.

Select one:

- Waiver capacity is allocated/managed on a statewide basis.
- Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The state does not anticipate deferring the entrance of otherwise eligible persons.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1.	State Classification. The State is a (select one):
	§1634 State
	SSI Criteria State
	© 209(b) State
2.	Miller Trust State.
	Indicate whether the State is a Miller Trust State (select one):
	© No
	© Yes
unde	icaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible rethe following eligibility groups contained in the State plan. The State applies all applicable federal financial cipation limits under the plan. <i>Check all that apply</i> :
	bility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 §435.217)
~	Low income families with children as provided in §1931 of the Act
~	SSI recipients
	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
	Optional State supplement recipients
	Optional categorically needy aged and/or disabled individuals who have income at:
	Select one:
	100% of the Federal poverty level (FPL)
	6 % of FPL, which is lower than 100% of FPL.
	Specify percentage:
	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in
/	§1902(a)(10)(A)(ii)(XIII)) of the Act) Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as
	provided in §1902(a)(10)(A)(ii)(XV) of the Act) Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage
	Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act) Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134
	eligibility group as provided in §1902(e)(3) of the Act) Medically needy in 209(b) States (42 CFR §435.330)
	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
	Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the
	State plan that may receive services under this waiver)
	Specify:
	opecy).
Snee	ial home and community-based waiver group under 42 CFR §435.217) Note: When the special home and
	nunity-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- © Yes. The State furnishes waiver services to individuals in the special home and community-based waiver

anoun	under	12	CED	\$435 217	
group	under	42	CFK	8435.217	

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seieci	one	unu	comp	$ieie$ $_{I}$	$1 \mu \mu$	enai	\sim 1	ט-ט	٠.

All individuals in the special home and community-based waiver group under 42 CFR §435.217
 Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

Check each that applies:

V	A	special	income	level	equal	to:
----------	---	---------	--------	-------	-------	-----

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

• A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- **100% of FPL**
- % of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules

under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- **a.** Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):
 - © Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act. (Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) (Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.

 (Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

i.

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

Allowance for the needs of the waiver participant (select one):	
The following standard included under the State plan	
Select one:	
SSI standard	
Optional State supplement standard	
Medically needy income standard	
The special income level for institutionalized persons	
(select one):	
© 300% of the SSI Federal Benefit Rate (FBR)	
A percentage of the FBR, which is less than 300%	
Specify the percentage:	
A dollar amount which is less than 300%.	
Specify dollar amount:	
A percentage of the Federal poverty level	

	Specify percentage:
0	Other standard included under the State Plan
	Specify:
C The	e following dollar amount
Spe	ecify dollar amount: If this amount changes, this item will be revised.
6 The	e following formula is used to determine the needs allowance:
Spe	ecify:
gua W <i>A</i>	100% of the Federal poverty level as a personal needs allowance, b) An allowance for the payment ardianship fees of the individual under a Superior Court order of guardianship as allowed under the AC, c) Earned income for the first \$65 plus one-half of the remaining earned income, d) total need I not exceed SIL" for the maintenance needs of the waiver participants.
	ecify:
© Not	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
Not The spo	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community
Not The spo	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
© Nor The spo	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:
© Nor The spo	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one):
© Nor The spo	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one): SSI standard
© Nor The spo	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard
© Not Spe	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard Medically needy income standard
Spe	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard Medically needy income standard
Spe	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard Medically needy income standard The following dollar amount: Specify dollar amount: If this amount changes, this item will be revised.
© Not Spe	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community ouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: ecify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard Medically needy income standard The following dollar amount: Specify dollar amount: If this amount changes, this item will be revised.
Spe	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community buse in §1924 of the Act. Describe the circumstances under which this allowance is provided: actify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard Medically needy income standard The following dollar amount: Specify dollar amount: If this amount changes, this item will be revised. The amount is determined using the following formula:
Spe	t Applicable e state provides an allowance for a spouse who does not meet the definition of a community buse in §1924 of the Act. Describe the circumstances under which this allowance is provided: actify: ecify the amount of the allowance (select one): SSI standard Optional State supplement standard Medically needy income standard The following dollar amount: Specify dollar amount: If this amount changes, this item will be revised. The amount is determined using the following formula:

	0	AFDC need standard
	6	Medically needy income standard
	0	The following dollar amount:
		Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
	0	The amount is determined using the following formula:
		Specify:
	0	Other
		Specify:
iv.		ounts for incurred medical or remedial care expenses not subject to payment by a third party, ified in 42 §CFR 435.726:
	a b	Health insurance premiums, deductibles and co-insurance charges Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.
	Sele	ct one:
	0	Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
	0	The State does not establish reasonable limits.
	6	The State establishes the following reasonable limits
		Specify:
		The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.
Appendix	B: I	Participant Access and Eligibility
		Post-Eligibility Treatment of Income (3 of 4)
c. Regul	ar Po	st-Eligibility Treatment of Income: 209(B) State.
		rovided in Appendix B-4 indicate that you do not need to complete this section and therefore this ot visible.
		Particinant Access and Fligibility

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i.	Allo	wance for the personal needs of the waiver participant
	(sele	ect one):
	0	SSI standard
	0	Optional State supplement standard
		Medically needy income standard
	0	The special income level for institutionalized persons
		A percentage of the Federal poverty level
		Specify percentage:
	0	The following dollar amount:
		Specify dellar amount: If this amount shances, this item will be revised
	6	Specify dollar amount: If this amount changes, this item will be revised
	(6)	The following formula is used to determine the needs allowance:
		Specify formula:
		a) Personal Needs Allowance - 100% of the Federal poverty level for a participant who does not reside with a community spouse or the Medically Needy income standard for a participant who does reside with a community spouse, b) An allowance for the payment of guardianship fees of the individual under a Superior Court order of guardianship as allowed under the WAC, c) Earned income for the first \$65 plus one-half of the remaining earned income, d) total needs will not exceed SIL" for the maintenance needs of the waiver participants.
	0	Other
		Specify:
ii.	fron §435	the allowance for the personal needs of a waiver participant with a community spouse is different in the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR 5.735, explain why this amount is reasonable to meet the individual's maintenance needs in the munity.
	Sele	ct one:
	0	Allowance is the same
	6	Allowance is different.
		Explanation of difference:

Additional funds can be allocated to a community spouse who resides with the participant. iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party,

specified in 42 §CFR 435.726:

ii.

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- The State does not establish reasonable limits.
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- **a.** Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:
 - i. Minimum number of services.

The minimum number of waiver service	es (one or more)	that an individual	must require in	order to be
determined to need waiver services is:	1			

- ii. Frequency of services. The State requires (select one):
 - The provision of waiver services at least monthly
 - Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b.	Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (<i>select one</i>):	
	Directly by the Medicaid agency	
	By the operating agency specified in Appendix A	
	By an entity under contract with the Medicaid agency.	
	Specify the entity:	

Other

Specify:

The Medicaid agency performs the initial evaluation for level of care. Re-evaluations for residential settings are performed by the local offices of the Medicaid Agency: Home and Community Services; re-evaluations for inhome are performed by Area Agencies on Aging who are under contract with the Medicaid agency.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Initial evaluations are performed by case managers who can be a Registered Nurse (licensed in the State) or a Social Worker. For Social Workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

Job classification discriptions are available from the Medicaid agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool is fully specified in WAC 388-106-0355 (eligiblity for nursing facility care services).

Nursing Facility Level of Care (NFLOC)is based on the following factors:

- 1. The Comprehensive Assessment Reporting Eavaluation (CARE) tool is the assessment tool used to determine NFLOC. Functional criteria for NFLOC means one of the following applies:
- a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis;
- b. The individual has an unmet or partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self performance and/or support provided (self performance and support provided is defined below).

The minimum level of assistance required for each ADL is:

- -Eating Support provided is setup; or
- -Toileting and bathing Self performance is supervision; or
- -Transfer, bed mobility, and ambulation Self performance is supervision and support provided is setup; or
- -Medication management Self performance is assistance required; or
- -If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

- c. The individual has an unmet or partially met need with at least two of the following activities of daily living: The minimum level of assistance required for each ADL is:
- -Eating Self performance is supervision and support provided one person physical assist; or
- -Toileting Self performance is extensive assistance and support provided is one person physical assist; or
- -Bathing Self performance is limited assistance and support provided is one person physical assist; or
- -Transfer and Mobility Self performance is extensive assistance and support provided is one person physical assist; or
- -Bed Mobility includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
- -Medication Management Assistance required daily in self performance; or
- -If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or
- (d) The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

The minimum level of assistance required for each ADL is:

- -Eating Self performance is supervision and support provided one person physical assist; or
- -Toileting Self performance is extensive assistance and support provided is one person physical assist; or
- -Bathing Self performance is limited assistance and support provided is one person physical assist; or
- -Transfer and Mobility Self performance is extensive assistance and support provided is one person physical assist; or
- -Bed Mobility includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
- -Medication Management Assistance required daily in self performance; or
- -If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.

"Self performance for ADLs" means what the individual actually did in the last seven days before the assessment, not what he/she might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period. Self-performance definitions and assessments are consistant with that used under the Minimum Data Set (MDS). This provides a common set of clinical data across all long term care settings. Self performance level is scored as:

- (a) Independent if the individual received no help or oversight, or if the individual needed help or oversight only once or twice:
- (b) Supervision if the individual received oversight (monitoring or standby), encouragement, or cueing three or more times;
- (c) Limited assistance if the individual was highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;
- (d) Extensive assistance if the individual performed part of the activity, but on three or more occasions, the individual needed weight bearing support or the individual received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means the individual needed physical help with part of the activity (other than transfer);
- (e) Total dependence if the individual received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by the individual in all aspects of the ADL; or
- (f) Activity did not occur if the individual or others did not perform an ADL over the last seven days before the individual's assessment. The activity may not have occurred because:
 - (i) The individual was not able (e.g., walking, if paralyzed);
 - (ii) No provider was available to assist; or

(iii) The individual declined assistance with the task.

"Support provided" means the highest level of support provided to the individual by others in the last seven days before the assessment, even if that level of support occurred only once.

- (a) No set-up or physical help provided by others;
- (b) Set-up help only provided, which is the type of help characterized by providing the individual with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);
 - (c) One-person physical assist provided;
 - (d) Two- or more person physical assist provided; or
 - (e) Activity did not occur during entire seven-day period.

Washington uses an automated assessment system called the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate and reevaluate level of care criteria required by the waiver. The CARE tool is available to CMS upon request through the Medicaid agency.

The functions, elements and scoring mechanisms of CARE are spelled out in the Washington State Administrative Code (WAC). The following WACs govern CARE and CARE classifications;

388-106-0050 What is an assessment?

388-106-0055 What is the purpose of an assessment?

388-106-0060 Who must perform the assessment?

388-106-0065 What is the process for conducting an assessment?

388-106-0070 Will I be assessed in CARE?

388-106-0075 How is my need for personal care services assessed in CARE?

388-106-0080 How is the amount of long-term care services I can receive in my own home or in a residential facility determined?

388-106-0085 What criteria does the CARE tool use to place me in one of the classification groups?

388-106-0090 How does the CARE tool measure cognitive performance?

388-106-0095 How does the CARE tool measure clinical complexity?

388-106-0100 How does the CARE tool measure mood and behaviors?

388-106-0105 How does the CARE tool measure activities of daily living (ADLs)?

388-106-0110 How does the CARE tool evaluate me for the exceptional care classification of in-home care?

388-106-0115 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place me in a classification group for residential facilities?

388-106-0120 What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility?

388-106-0125 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110, to place me in a classification group for in-home care?

388-106-0130 How does the department determine the number of hours I may receive for in-home care?

388-106-0135 What are the maximum hours that I can receive for in-home services?

388-106-0140 What will change the maximum hours I can receive?

- **e.** Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):
 - The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Case managers complete Level of Care evaluations using the automated assessment tool (CARE). CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed initially, at annual review, and when a significant change occurs. State case managers' complete initial evaluations, and annual and significant change assessment for individuals in residential settings. AAA case managers complete annual and significant change reviews for individuals receiving care in their own home. The recipient's assigned case manager is responsible for completing re-evaluations.

Information about the person's support needs is obtained via a face to face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, home health agencies, caregivers and family.

- **g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:
 - **Every three months**
 - Every six months
 - Every twelve months
 - Other schedule

Specify the other schedule:

Re-evaluations must be completed every twelve months and whenever there is a significant change in the client's condition

- **h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations *(select one)*:
 - The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
 - The qualifications are different. Specify the qualifications:

i.	Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State
	employs to ensure timely reevaluations of level of care (specify):

The Social Services Payment System (SSPS) produces a report for each case manger that lists each authorization that is expiring or about to expire. Case managers use this information to assure the timeliness of annual reviews in addition to tickler reports produced by CARE.

HCS and AAA supervisors have a required schedule of record reviews for individual case managers and are responsible for evaluating staff on assessment timeliness. In addition, supervisors use reports produced by CARE to track timeliness of assessments.

Quality assurance staff monitoring of records includes monitoring for timeliness.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations is maintained for a minimum of three years at the state level. Written documentation of all evaluation and reevaluations are maintained for a minimum of three years at the local office.

Appendix B: Evaluation/Reevaluation of Level of Care

Quanty improvement. Level or care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of all applicants that have applied for a LOC determination and have a completed assessment. (Excludes individuals that withdrew their request, died, or are not financially eligible) N=All waiver applicants who have a completed LOC assessment D=All waiver applicants

Data Source (Select one): **Other** If 'Other' is selected, specify:

Administrative Data

Administrative Data Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	☐ Weekly	✓ 100% Review
Operating Agency	☐ Monthly	☐ Less than 100% Review
Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	▽ Continuously and Ongoing	Other Specify:

Other Specify:	

Data Aggregation and Analysis:		
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	
▼ State Medicaid Agency	™ Weekly	
Operating Agency	™ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	✓ Annually	
	Continuously and Ongoing	
	Other Specify:	

b. Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of waiver participants who received a redetermination of LOC within annual time frame. N=All waiver participants who received a timely annual redetermination of LOC D=All waiver participants reviewed where a redetermination was due

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

data collection/generation (check each that applies): (check each that applies):
--

State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	V Less than 100% Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	☐ Continuously and Ongoing	Other Specify:
	Specify: 18 month review cycle	

Data Aggregation and Analysis:

Data Aggregation and Analysis:		
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	
State Medicaid Agency	☐ Weekly	
☐ Operating Agency	☐ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	✓ Annually	
	Continuously and Ongoing	
	Specify: 18 month review cycle	

Performance Measure:

Percent of significant changes that occured when warranted by changed in the waiver participants needs N: Number of records reviewed where a significant change assessemnt was completed when indicated D: Number of records reviewed

Data Source (Select one): **Record reviews, off-site** If 'Other' is selected, specify:

· · · · · · · · · · · · · · · · · ·	
Responsible Party for Frequency of data Sampling Approach	

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	□ Weekly	☐ 100% Review
Operating Agency	™ Monthly	Less than 100% Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	☐ Continuously and Ongoing	Other Specify:
	Other Specify: 18 months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	✓ Annually
	Continuously and Ongoing
	Other Specify: 18 months

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance

measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

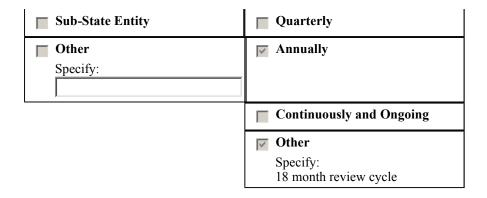
Data Source (Select one):

Overall proficiency for all QA questions N: Number of questions reviewed that meet proficiency standard per Region/AAA D: Number of questions reviewed

Other If 'Other' is selected, specify: QA database **Responsible Party for** Frequency of data Sampling Approach collection/generation (check each that applies): data collection/generation (check each that applies): (check each that applies): **▼** State Medicaid ■ Weekly **№** 100% Review Agency Operating Agency **■** Monthly **■** Less than 100% Review **■** Sub-State Entity Quarterly Representative Sample Confidence Interval = □ Other **✓** Annually **■ Stratified** Specify: Describe Group: ☐ Other Continuously and **Ongoing** Specify: **Other** Specify: 18 month review cycle

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly



ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CARE assessment as specified in the waiver is the only assessment tool used to determine LOC. To determine LOC, case managers use CARE which is a standardized assessment tool base on the MDS. QA staff and supervisors/managers monitor for appropriate application of the CARE instrument and processes to meet sub-assurance c: (The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care).

Social service supervisors/managers annually monitor four records per experienced worker to ensure LOC accuracy and that a LOC is determined annually or at significant change (approximately 2500 reviews statewide). For new staff, a minimum of 50% of LOCs are reviewed during the first six months of employment. Errors in assessment that can lead to an inaccurate LOC determination are corrected. ADSA QA unit monitors LOC using a statistically valid sample of records statewide on an 18 month review cycle approved description to determine participant level of care.

Monitoring activities and data provide evidence of use of the CARE application. LOC determinations that are not correctly determined are corrected and correction is verified at second review. Training to address use of the CARE application is developed based on the data: individual, unit, regional or statewide.

CARE enforces rules of eligibility. An algorithm in CARE determines LOC based on information entered in to the assessment by the participant and case manager. A LOC determination is completed on all applicants for whom there is reasonable indication that services may be needed in the future. If the participant is not COPES eligible, the option is not available for the case manager to select/ participant to choose and will not print on the service summary (plan of care).

- -An Intake is completed at the state agency (HCS) within two working days of receiving the request/referral for services referrals are entered within one working day for applicants discharging from the hospital.
- The case is assigned to a social worker (the primary case manager) within one working day of the intake date
- A face-to-face contact is made within two working days of receipt of the referral for applicants coming home from the hospital.
- The assessment process must be completed and services authorized (if eligible) within 30 days of the date of assignment.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 - CARE, QA and payment reports are reviewed and corrective action taken on an on-going basis by supervisors and field managers. Case managers are required to take action with specified time frames to address all inappropriate LOC determinations identified during the supervisory and QA unit monitoring. CARE management reports include data elements such as: intake date, first assigned date, primary case manager, date assessment created, date moved from pending to current (make payment), setting and transfer dates.
 - Quality assurance proficiency and follow-up reports (Proficiency Report for Follow-Up Review outlines LOC decisions and corrective actions taken) document prompt assessment and eligibility determinations,

accuracy, and corrective action. QA roll up reports are reviewed at all levels of the system: case managers, individualized proficiency reports; supervisors, unit reports; HCS Regional Administrators and AAA Directors, regional reports; and ADSA headquarters, reviews analyzes regional and statewide aggregate data.

Corrective actions plans are required for areas where required proficiency levels are not achieved or if improvement is not evident based upon previous corrective actions. Corrective action plans are evaluated and individualized prior to approval to ensure that plan will effectively address areas that need improvement. Training elements of corrective action plans are coordinated through DSHS and DSHS staff is made available to provide training and technical support. An update at six months is required to report on progress toward implementing corrective actions.

Each Region/AAA develops an annual training plan that outlines how mandatory and optional training will occur for new and experienced staff (employed one year or longer). This document is revised annually at the regional/PSA level and may be reviewed by the QAS during the HCA/AAA review cycle. A separate plan does not need to be developed if these elements are included in the corrective action plan.

Identified statewide trends are forwarded to the ADSA program managers and Training, Development and Communication unit for training development.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	☐ Monthly
Sub-State Entity	☐ Quarterly
Other Specify: AAA	✓ Annually
	Continuously and Ongoing
	Other Specify: 18 month review cycle

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.





Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Sub-assurance b: performance measure: Percent of significant changes that occured when warranted by changed in the waiver participants needs. This performance measure will be added to the quality assurance review process starting in spring 2010 for the 2010/2011 review cycle.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department uses, a form called "Acknowledgement of Services", (DSHS 14-22) to document the applicant/recipient's freedom to choose between institutional and home and community-based services. The DSHS 14-225 is explained to the individual by the case manager or social worker and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

Fair Hearing information is contained on the DSHS document 14-225, "Acknowledgement of Services" form. Rights to a fair hearing are explained to all clients during the Medicaid application process and again during the assessment process.

The client receives a signed copy of the DSHS 14-225 and a copy of the form is maintained in the applicant/recipients' case records.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of forms are maintained for a minimum of 3 years in the client record at the local office where case management for the client occurs.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The following references govern access to services for Limited English proficient Persons:

RCW 74.04.025 Bilingual services for non-English speaking applicants and recipients -- Bilingual personnel, when -- Primary language pamphlets and written materials.

WAC 388-03 Rules and regulations for the certification of DSHS spoken language interpreters and translators.

WAC 388-271 Limited English proficient services.

DSHS Administrative Policies

6.12 Adjustment of Workload for Staff who Provide Translation and Interpretation Services Outside of their Workload

7.20 Communication Access for Persons Who are Deaf, Deaf/Blind and Hard of Hearing

7.21 Access to Services for Clients who are Limited English Proficient (LEP)

The Department of Social and Health Services and its contractors are required by statute, administrative code and department policy to deliver services that recognize individual and cultural differences. All clients must be given equal access to services, information, and programs whether the department or contracted vendors deliver services. The following are summaries of requirements:

- 1.Interpreters are used when interpreter services are requested by the client; necessary to determine a client's eligibility for services; necessary for the client to access services.
- 2.LEP and Sensory Impaired (SI) clients are informed of their right to request an interpreter or auxiliary aide and are offered interpreter services or auxiliary aids at no cost to them and without significant delay. Children under age 18 are not allowed to serve as interpreters. LEP Interpreters and Translators for spoken language must be certified and/or qualified by DSHS and comply with the DSHS code of professional conduct.
- 3.To assure access and quality, DSHS maintains a statewide translation contract, American Sign Language contract and

Interpreter Brokerage contract for Spoken Languages.

- 4. If the listed contractors cannot meet the need, or there is an emergency, which requires the immediate attention, staff can access the Language Line.
- 5. Procedures are in place to obtain translation of official publications, forms and records as well as client specific requests for translations.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Home Health Aide
Statutory Service	Personal Care
Other Service	Adult Day Care
Other Service	Caregiver/Recipient Training Services
Other Service	Community Transition Services
Other Service	Environmental Accessibility Adaptations
Other Service	Home Delivered Meals
Other Service	Managed Care Option - Capitated
Other Service	Nurse Delegation
Other Service	Personal Emergency Response
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment and Supplies
Other Service	Transportation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service	Type:
0	-

Alternate Service Title (if any):	
Home Health Aide	
Service:	
Statutory Service	

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- © Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services defined in 42 CFR §440.70 that are provided in addition to home health aide services furnished under the approved State plan. Home health aide services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from home health aide services

in the State plan. The differences from the State plan are as follows: Under the state plan, home health aid services require a physician order and must be provided under the supervision of an RN, occupational therapist, speech therapist or physical therapist. Under the waiver, home health aid services may be provided without a physician order and the tasks in the care plan performed by the aide are supervised by an RN as needed and in coordination with the client's case manager. Home health aid services are not required to meet the requirements for participation in Medicare as provided in 42 CFR 489.28.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provided only as identified in the participant's CARE assessment and plan.

Service Delivery Method (check	к еасп	tnat	appiies)
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- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- **■** Legally Responsible Person
- Relative
- □ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Certified Nursing Assistant
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service	
Service Name: Home Health Aid	le

Provider Category:

Individual 🔻

Provider Type:

Certified Nursing Assistant

Provider Qualifications

License (specify):

Certificate (specify):

Certified and registered under Chapter 18.88A RCW and Chapter 246-841 WAC

Other Standard (specify):

Pass background check

Verification of Provider Qualifications

Entity Responsible for Verification:

State or AAA

Frequency of Verification:

Upon contracting and per individual certification schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name: Home Health Aide

Provider Category:

Agency 🔽
Provider Type:
Home Health Agency
Provider Qualifications
License (specify):
licensed under Chapter 70.127 RCW
Certificate (specify):

Other Standard (specify):

Individual nursing assistants employed by an agency must be certified under Chapter 18.88A RCW and Chapter 246-841 WAC

Verification of Provider Qualifications

Entity Responsible for Verification:

State or AAA

Frequency of Verification:

Upon contracting and per license renewal schedule

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Statutory Service

Service:
Personal Care

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Personal care under the waiver differs in scope from personal care services in the State plan in that it may only be provided to waiver participants who are not eligible for State plan personal care or whose needs exceed what can be provided solely under State plan personal care. Assistance is provided to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. Health-related services that are provided may include skilled or nursing care and medication administration to the extent permitted by State law. Providers are paid once for the same hour of service.

Nursing tasks, such as administration of medication, blood glucose monitoring, insulin injections, ostomy care, simple wound care or straight catheterization, may be delegated under the direction of a licensed, registered nurse if the provider meets the requirements of a nursing assistant certified and/or registered in the State of Washington. The following tasks CANNOT be delegated: Injections other than insulin, central lines, sterile procedures, and tasks that require nursing judgments. Providers are paid once for the same hour of service.

Participants may elect to have employer authority for Individual Providers (IPs) including hiring, firing, scheduling and supervision. If a participant is unable to provide supervision, an alternate supervisor must be

identified. Participants may elect to obtain personal care services through a home care agency.

Personal care includes assistance with bathing, bed mobility, body care, dressing, eating, locomotion, walking, medication management, toileting, transfer and personal hygiene.

Personal care includes assistance the following incidental activities of daily living: meal preparation, ordinary housework, essential shopping, wood supply (when wood is the sole source of heat), travel to medical services, assessment of the need for financial management and telephone use. These incidental activities may not comprise the entirety of the service for an individual.

Personal care may be provided outside of the participant's home as specified in the service plan. Personal care may be furnished to escort participants to participate in community activities or access other services in the community. Personal care may be furnished in order to assist a person to function in the work place or as an adjunct to the provision of employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- Personal Care may not may not be duplicative of any other waiver service.
- •The maximum hours of personal care received are determined by the Medicaid Agency through the approved department assessment for Personal Care services.
- •Provider rates are determined by the Legislature based on negotiations between the union representing individual providers and the Governor's office, and state statute for home care agencies.
- •Payments flow directly from the Single State Agency to the agency provider or individual provider of services.
- •Body care excludes:
 - (i) Foot care if the participant is diabetic or has poor circulation; or
 - (ii) Changing bandages or dressings when sterile procedures are required.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- **▼** Provider managed

Specify whether the service may be provided by (check each that applies):

- **■** Legally Responsible Person
- Relative
- □ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Assistant
Agency	Home Care Agency/ Home Health Agency
Agency	Assisted Living/Enhanced Adult Residential Care
Agency	Adult Family Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service	Type:	Statutory	Service
Service	Name	: Personal	Care

Provider Category:

Individual 🔻

Provider Type:
Personal Assistant

Provider Qualifications

License (specify):	
Certificate (specify):	

Other Standard (specify):

Individual providers must contract with the Department before providing personal care services. The case manager is responsible for completing all contracting steps. Prior to contracting the case manager must verify that the individual provider:

- a. is authorized to work in the United States
- b. Has passed a background check
- c. is age 18 or older

Individual providers must complete that following training requiremens:

- 1. Caregiver orientation within 14 days
- 2. Revised Fundamentals of Caregiving must be completed within 120 days of employment. Note: An IP may take the Modified Fundamentals of Caregiving Self-Study course in lieu of the full Fundamentals course, if the IP documents successful completion of training as an RN, LPN, nursing assistant certified, PT, OT, or a Medicare certified home care aide.
- 3. Continuing education of 10 hours each calendar year
- 4. Required training as outlined in WAC 388-71-05805 through WAC 388-71-05830, for an IP who will be performing a nurse delegated task.

Individual providers of personal care are regulated under the following sections of Washington Administrative Code:

INDIVIDUAL PROVIDER AND HOME CARE AGENCY PROVIDER QUALIFICATIONS

388-71-0500 What is the purpose of WAC 388-71-0500 through 388-71-05909?

388-71-0505 How does a client hire an individual provider?

388-71-0510 How does a person become an individual provider?

388-71-0513 Is a background check required of a home care agency provider?

388-71-0515 What are the responsibilities of an individual provider or home care agency provider when employed to provide care to a client?

388-71-0520 Are there training requirements for an individual provider or a home care agency provider of an adult client?

388-71-0540 When will the department, AAA, or managed care entity deny payment for services of an individual provider or home care agency provider?

388-71-0546 When can the department, AAA, or managed care entity reject the client's choice of an individual provider?

388-71-0551 When can the department, AAA, or managed care entity terminate or summarily suspend an individual provider's contract?

388-71-0556 When can the department, AAA, or managed care entity otherwise terminate an individual provider's contract?

388-71-0560 What are the client's rights if the department denies, terminates, or summarily suspends an individual provider's contract?

388-71-05640 Self-directed care -- Who must direct self-directed care?

388-71-05665 What definitions apply to WAC 388-71-05670 through 388-71-05909? ORIENTATION

388-71-05670 What is orientation?

388-71-05675 What content must be included in an orientation?

388-71-05680 Is competency testing required for orientation?

388-71-05685 Is there a challenge test for orientation?

388-71-05690 What documentation is required for orientation?

388-71-05695 Who is required to complete orientation, and when must it be completed?

BASIC TRAINING

388-71-05700 What is basic training?

388-71-05705 Is there an alternative to the basic training for some health care workers?

388-71-05710 What core knowledge and skills must be taught in basic training?

388-71-05715 Is competency testing required for basic training?

388-71-05720 Is there a challenge test for basic training?

388-71-05725 What documentation is required for successful completion of basic training?

388-71-05730 Who is required to complete basic training, and when?

MODIFIED BASIC TRAINING

388-71-05735 What is modified basic training?

388-71-05740 What knowledge and skills must be included in modified basic training?

388-71-05745 Is competency testing required for modified basic training?

388-71-05750 Is there a challenge test for modified basic training?

388-71-05755 What documentation is required for successful completion of modified basic training?

388-71-05760 Who may take modified basic training instead of the full basic training?

EXEMPTION FOR IP PARENTS FOR ADULT CHILDREN

388-71-05765 What are the training requirements and exemptions for parents who are individual providers for their adult children receiving services through DDD?

388-71-05770 What are the training requirements and exemptions for parents who are individual providers for their adult children who do not receive services through DDD?

CONTINUING EDUCATION

388-71-05775 What is continuing education?

388-71-05780 How many hours of continuing education are required each year?

388-71-05785 What kinds of training topics are required for continuing education?

388-71-05790 Is competency testing required for continuing education?

388-71-05795 May basic or modified basic training be completed a second time and used to meet the continuing education requirement?

388-71-05799 What are the documentation requirements for continuing education?

NURSE DELEGATION CORE TRAINING

388-71-05805 What is nurse delegation core training?

388-71-05810 What knowledge and skills must nurse delegation core training include?

388-71-05815 Is competency testing required for nurse delegation core training?

388-71-05820 Is there a challenge test for nurse delegation core training?

388-71-05825 What documentation is required for successful completion of nurse delegation core training?

388-71-05830 Who is required to complete nurse delegation core training, and when?

SAFETY TRAINING

388-71-05832 What is safety training?

COMPETENCY TESTING

388-71-05835 What is competency testing?

388-71-05840 What components must competency testing include?

388-71-05845 What experience or training must individuals have to be able to perform competency testing?

388-71-05850 What training must include the DSHS-developed competency test?

388-71-05855 How must competency test administration be standardized?

388-71-05860 What form of identification must providers show a tester before taking a competency or challenge test?

388-71-05865 How many times may a competency test be taken?

INSTRUCTOR QUALIFICATIONS

388-71-05870 What are an instructor's or training entity's responsibilities?

388-71-05875 Must instructors be approved by DSHS or an AAA?

388-71-05880 Can DSHS or the AAA deny or terminate a contract with an instructor or training entity?

388-71-05885 What is a guest speaker, and what are the minimum qualifications to be a guest speaker for basic training?

388-71-05890 What are the minimum qualifications for an instructor for basic, modified basic or nurse delegation core training?

388-71-05895 What additional qualifications are required for instructors of nurse delegation core training?

PHYSICAL RESOURCES AND STANDARD PRACTICES FOR TRAINING

388-71-05899 What must be included in a class on adult education?

388-71-05905 What physical resources are required for basic, modified basic, or nurse delegation core classroom training and testing?

388-71-05909 What standard training practices must be maintained for basic, modified basic, or nurse delegation core classroom training and testing?

Verification of Provider Qualifications

Entity Responsible for Verification:

Case manager

Frequency of Verification:

Initially and every two years for background checks. If there is reasonable cause to believe that the provider has been arrested or convicted of a disqualifying crime within the two year cycle, the case manager must complete a new background check.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Care Agency/ Home Health Agency

Provider Qualifications

License (specify):

licensed under chapter 70.127 RCW and chapter 246-336 WAC or Home Health Agency License under Chapter 70.127 RCW

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon executing/renewing contract

License renewal every two years

Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Assisted Living/Enhanced Adult Residential Care

Provider Qualifications

License (specify):

BH License under Chapter 18.20 RCW, Chapter 388-110 WAC

Certificate (specify):

Other Standard (specify):

Entity Responsible for Verification:

State

Frequency of Verification:

Upon executing/renewing contract License renewal every two years Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:
| Agency | Provider Type:
| Adult Family Home
| Provider Qualifications |
| License (specify):
| AFH License under Chapter 70.128 RCW and WAC 388-76 |
| Certificate (specify): |
| Other Standard (specify): |

Verification of Provider Qualifications

Entity Responsible for Verification:

State

Frequency of Verification:

Upon executing/renewing contract License renewal every two years

Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Adult Day Care: Adult Day Care Services provided in an adult day care center include provision of personal care; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours

a day in a group setting on a continuing, regularly scheduled basis.

Services also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regimen; and, programming and activities designed to meet clients' physical, social and emotional needs.

Adult day care shall be included in a recipient's approved plan of care only when the recipient is; ineligible for adult day health services (Medicaid State Plan covered services): has mild to moderate dementia and/or is chronically ill or disabled; is socially isolated and/or confused; is unable/unsafe to be left alone during the day; needs assistance with personal care; and will benefit from an enriched socially supportive experience.

Personal Care service hours are reduced 30 minutes for each hour of Adult Day Care in order to avoid duplication of personal care services since it is assumed that some personal care needs will be met by Adult Day Care services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult Day Care may not may not be duplicative of any other waiver service.

Service Delivery Method	(check each tha	t applies):
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	I al tici	pant-un ceteu	as s	pecineu	111 /	ZPPCII	UIA .	Ľ

Provider managed

Specify whether the service may be provided by (check each that applies):

■ Legally Responsible Person

■ Relative

□ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service	
Service Name: Adult Day Care	
rovider Category:	
Agency	
rovider Type:	
dult Day Care Center	
rovider Qualifications	

License (specify):

| Certificate (specify):

Other Standard (specify):

Meet the requirements of Chapter 388-71-0702 through 388-71-0776 WAC

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon initial contracting

Annual review per WAC 388-71-0724

Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws,	regulations and policies	referenced in the	specification a	are readily	available to C	MS upon reques	st
through the	e Medicaid agency or the	operating agency	(if applicable).			

Service Type: Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Caregiver/Recipient Training Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Recipient training needs are identified in the CARE assessment or in a professional evaluation. This service is provided in accordance with a therapeutic goal in the plan of care and includes for example, adjustment to serious impairment, maintenance or restoration of physical functioning, self management of chronic disease, acquisition of skills to address minor depression, management of personal care, and development of skills to work with care providers including behavior management.

Training services are mandated for each paid caregiver and provide instruction in either a one-to-one situation or in a group setting. Each caregiver shall receive a two (2) hour orientation and additional twenty eight (28) hours basic training, and ten (10) hours continuing education.

The caregiver training curriculum includes: use of special or adaptive equipment or medically related procedures required to maintain the recipient in the home or community-based setting; and, activities of daily living. In addition, caregiver training teaches critical care giving skills including: client rights and abuse reporting; observation and reporting changes in client condition; infection control, accident prevention, food handling and other information on providing a safe environment; emergency procedures and problem solving. Specify applicable (if any) limits on the amount, frequency, or duration of this service:

-Caregiver/Recipient Training services may not may not be duplicative of any other waiver service.

-Service provided only as identified in the participant's CARE assessment and plan. Only 20 units (hours) may be authorized in a six month period.

Service Delivery Method (check each that applies):

	Participant-directed	as specified	in Appen	dix E
V	Provider managed			

Provider managed

		ce may					

■ Legally Responsible Person

■ Relative

■ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Chronic Disease Self Management Trainer
Agency	Community Mental Health Agency
Agency	Home Health Agency
Individual	Certified Dietician/Nutritionist
Individual	Independent Living Provider
Individual	Physical Therapist
Individual	Licensed Pratical Nurse
Agency	Chronic Disease Self Management Trainer
Agency	Home Care Agency
Individual	Registered Nurse
Agency	Community College
Agency	Centers for Independent Living
Individual	Pharmacist
Individual	Human Service Professional
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual 🔻

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License (specify):

Certificate (specify):

Certification in an evidence based chronic disease self management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per individual certification schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Agency

Provider Type:

Community Mental Health Agency

Provider Qualifications

License (specify):

Licensed under Chapter 388-865-0400 WAC

Certificate (specify):

Other Standard (specify):

Capacity to provide services to individual that do not meet access to care standards in the public mental health system

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per agency licensing schedule thereafter

Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Home Health Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per agency licensing schedule thereafter

Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual 🔻

Provider Type:

Certified Dietician/Nutritionist

Provider Oualifications

License (specify):

Certificate (specify):

Dietician and Nutritionist certificate under Chapter 18.138 RCW

Other Standard (specify): Verification of Provider Qualifications **Entity Responsible for Verification:** State/AAA **Frequency of Verification:** Upon contracting and per individual certification schedule thereafter **Appendix C: Participant Services** C-1/C-3: Provider Specifications for Service **Service Type: Other Service** Service Name: Caregiver/Recipient Training Services **Provider Category:** Individual 🔻 **Provider Type: Independent Living Provider Provider Qualifications** License (specify): **Certificate** (specify): **Other Standard** (specify): A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of independent living services; or, Two years experience in the coordination or provision of independent living services (e.g. housing, personal assistance services recruitment or management, independent living skills training) in a social service setting under qualified supervision; or, Four years personal experience with a disability. **Verification of Provider Qualifications Entity Responsible for Verification:** State/AAA **Frequency of Verification:** Upon contracting and as necessary thereafter **Appendix C: Participant Services** C-1/C-3: Provider Specifications for Service **Service Type: Other Service** Service Name: Caregiver/Recipient Training Services **Provider Category:** Individual 🔻 **Provider Type: Physical Therapist Provider Qualifications License** (specify): PT license under Chapter 18.74 RCW **Certificate** (specify): Other Standard (specify):

Verification of Provider Qualifications Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual 🔻

Provider Type:

Licensed Pratical Nurse

Provider Qualifications

License (specify):

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State or AAA

Frequency of Verification:

Prior to contracting and per individual licensing schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Agency ▼

Provider Type:

Chronic Disease Self Management Trainer

Provider Qualifications

License (specify):

Public Health and Safety providers licensed under Chapter 70 RCW.

Certificate (specify):

Other Standard (specify):

Individual Employee Qualification: Certification in an evidence based chronic disease self management training program such as the Stanford University Chronic Disease Self Management Program (CDSMP).

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per agency licensing schedule and per individual certification schedule thereafter

Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License (specify):

Home Care Agency license under Chapter 70.127 RCW and Chapter 246-335 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per agency licensing schedule thereafter

Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual 🔻

Provider Type:

Registered Nurse

Provider Qualifications

License (specify):

RN license under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider	Category:

Agency Provider Type:

Community College

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Higher Education Institution conducting programs under Chapter 28B.50.020 RCW

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and as necessary

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Agency

Provider Type:

Centers for Independent Living

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Community based non-profit organizations in Washington State which provide services by and for people with disabilities. Centers for Independent Living receive funding through the Federal Department of Education/Rehabilitation Services Administration and are contracted in the state of Washington through the Department's Division of Vocational Rehabilitation.

Verification of Provider Qualifications

Entity Responsible for Verification:

AAA/State

Frequency of Verification:

Upon executing/renewing contract

Contract compliance monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual -

Provider Type:

Pharmacist

Provider Qualifications

License (specify):

Licensed per Chapter 18.64 RCW and Chapter 246.863 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual 🔻

Provider Type:

Human Service Professional

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):
Bachelor's in degree or higher in Psychology, Social Work or a related field with a minimum of two years experience providing services to aging or disabled populations.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon Contracting and at each contract renewal

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Caregiver/Recipient Training Services

Provider Category:

Individual 🔻

Provider Type:

Occupational Therapist

Provider Qualifications

License (specify):

OT license under Chapter 18.59 RCW

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per individual licensing schedule thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- © Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Community Transitions Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary home accessibility adaptations; and, (g) activities to assess need, arrange for and procure need resources. This service includes the training of participants and caregivers in the maintainance or upkeep of equipment purchased only under the service and does not duplicate training provided under other waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: Service provided only as identified in the participant's CARE assessment and plan.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; room and board; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Community transition services may not be used to furnish or set up living arrangements that are owned or leased by a waiver provider.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

■ Legally Responsible Person

■ Relative

□ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency Community Transition Service Provider
Individual	Individual Community Transition Service Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition Services

Provider Category:

Agency

Provider Type:

Agency Community Transition Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The providers of community transition services vary based on the needs of the individual client. Providers must meet any licensing or certification required by State statute or regulation to provide their services. Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon arranging for payment and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition Services

Provider Category:

Individual 🔻

Provider Type:

Individual Community Transition Service Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The providers of community transition services vary based on the needs of the individual client. Providers must meet any licensing or certification required by State statute or regulation to provide their services. Additionally if the needed service is not one that is regulated, the State will ensure that such services are delivered as specified by waiver beneficiary and detailed in the plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon arranging for payment and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:



As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- © Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the participant.

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Environmental Accessability Adaptations includes the performance of

necessary assessments to determine the types of modifications that are necessary. Home modifications may be authorized up to 180 days in advance of the community transition of an institutionalized person.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provided only as identified in the participant's CARE assessment and plan.

Environmental Accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Home modification begun while a person is institutionalized is not considered complete until the date the person leaves the institution and enters the waiver.

Service Delivery Method (check each that applies):

☐ Participant ☑ Provider m	-directed as specified in Appendix E anaged	
Provider Category	Provider Type Title	
Individual	Home Modifications Contractor	
Individual	Volunteer	
Annendix C. Pa	articipant Services	
	C-3: Provider Specifications for Service	
C-1/C	3. I Tovider Specifications for Service	
Service Type: O	Other Service Environmental Accessibility Adaptations	
Provider Category: Individual Provider Type: Home Modifications Or Provider Qualification License (specify,	Contractor ons	
(1 33)		
Certificate (spec	cify):	
Verification of Provi	ds of Chapter 18.27 RCW Registration of Contractors ider Qualifications ible for Verification: erification:	
Appendix C: Pa	articipant Services	
C-1/C	C-3: Provider Specifications for Service	
Service Type: O Service Name: I	Other Service Environmental Accessibility Adaptations	
Provider Category: Individual Provider Type: Volunteer Provider Qualification License (specify) Certificate (specificate) Other Standard): cify): l (specify):	
Must sign confid	lentiality statement	

Knowledge of building codes as applicable to the specific task

Cost must be less than \$500 per Chapter 18.27.090(9) RCW (Volunteers are reimbursed for costs of supplies and materials but are not reimbursed for labor).

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA verify provider qualifications

Frequency of Verification:

Upon contracting for the task

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:



As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- © Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Home-delivered meal services provide nutritional balanced meals delivered to the recipient's home when meal provision is more cost effective than having a personal care provider prepare the meal. These meals shall not replace nor be a substitute for a full day's nutritional regimen but shall provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences, National Research Council. A unit of service equals one (1) meal. No more than one meal per day will be reimbursed under the waiver.

Home-delivered meals are provided to an individual at home and included in the approved plan of care only when the recipient is homebound, unable to prepare the meal and there is no other person, paid or unpaid, to prepare the meal. When a client's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by restaurants, cafeterias or caterers who comply with Washington State Department of Health and local board of health regulations for food service establishments.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- -Service provided only as identified in the participant's CARE assessment and plan.
- -no more that one meal per day reimbursed under the waiver
- -recipient must be homebound, unable to prepare the meal and there is no other person paid or unpaid to prepare the meal

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

☐ Legally Responsible Person

■ Relative

■ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Food Service Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Food Service Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Title III Home delivered nutrition program standards and Chapter 246-215 WAC (food service)

Verification of Provider Qualifications

Entity Responsible for Verification:

AAA

Frequency of Verification:

Upon contracting and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Managed Care Option - Capitated

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Clients who are eligible for COPES can choose to receive all of their services through a managed care organization. Services in the managed care option include all services available on the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service Delivery Method (check each that applies):
Participant-directed as specified in Appendix E
✓ Provider managed
Specify whether the service may be provided by (check each that applies): Legally Responsible Person
Relative
Legal Guardian
Provider Specifications:
Provider Category Provider Type Title
Agency Health Maintenance Organization
Appendix C: Participant Services
· · ·
C-1/C-3: Provider Specifications for Service
Service Type: Other Service Service Name: Managed Care Option - Capitated
Provider Category: Agency
Provider Type:
Health Maintenance Organization
Provider Qualifications
License (specify): Health maintenance organization is any organization receiving a certificate of registration by the Insurance Commissioner under Chapter 48.46 RCW which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040. Certificate (specify):
Other Standard (specify):
Verification of Provider Qualifications Entity Responsible for Verification: State Frequency of Verification: At initial contracting and each successive renewal of contract

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

	Service Type:	
I	Other Service	

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nurse Delegation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- © Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Nurse Delegation Services-A registered nurse delegator assesses a client for program suitability; and teaches, evaluates competency and supervises the performance of a nursing assistant. The nursing assistant has met additional educational requirements performs the delegated nursing tasks for a client. These tasks may include administration medications, blood glucose monitoring, insulin injections, ostomy care, simple wound care, straight catheterization or other tasks determined appropriate by the delegating nurse.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services do not duplicate personal care. Providers are paid once for the same hour of service.

Service provided only as identified in the participant's CARE assessment and plan.

The following tasks CAN NOT be delegated: Injections other than insulin, central lines, sterile procedures, and tasks that require nursing judgement.

Service provided per Chapter 18.79.260 RCW

Service Delivery Method (check each that applies):

	Participant-directed	as specified	in Appendix E
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Provider managed

Specify whether the service may be provided by (check each that applies):

■ Legally Responsible Person

■ Relative

■ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Registered Nurse

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service	Type:	Other	Service
Service	Name:	Nurse	Delegatio

Provider Category:

Agency

Provider Type:
Home Health Agency
Provider Qualifications

License (specify):

Licensed under Chapter 70.127 RCW

Certificate (specify):

Other Standard (specify):

Individual RNs employed by the agency must be licensed under Chapter 18.79 RCW and Chapter 246-840 WAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting

Contract monitoring every two years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service Service Name: Nurse Delegation

Provider Category:

Individual 🔻

Provider Type:

Registered Nurse

Provider Qualifications

License (specify):

Licensed under Chapter 18.79.040

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State or AAA

Frequency of Verification:

Upon contracting and per individual licensing schedule

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service is included in approved waiver. There is no change in service specifications.

- © Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is programmed to signal a response center once a "help" button is activated. Some PERS systems can also include medication reminders. The response center is staffed by trained professionals.

PERS services are limited to those individuals who live alone or with others who cannot summon help in an emergency , or who are alone or with others who cannot summon help in an emergency for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

- 1. All PERS equipment vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.
- 2. The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.
- 3. The emergency response communicator must not interfere with normal telephone use. The communicator must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability.

Installation and maintenance of the PERS syste is included in the service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service: Service provided only as identified in the participant's CARE assessment and plan.

PERS cannot be used solely for the purpose of medication reminders.

The participant must live alone or with others who cannot summon help in an emergency or must be alone with no regular caregiver for extended periods of time.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

■ Legally Responsible Person

■ Relative

□ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Electronic Communication Equipment and Monitoring Company

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response

Provider Category:

Agency	

Provider Type:

Electronic Communication Equipment and Monitoring Company

Provider Qualifications

License (specify):
Certificate (specify):

Other Standard (specify):

The monitoring agency must be capable of simultaneously responding to multiple signals for help from clients' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by back up power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS client's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

Verification of Provider Qualifications

Entity Responsible for Verification:

State

Frequency of Verification:

Every two years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State. Skilled nursing services under the waiver differ in nature, scope, supervision arrangements, or provider type (including provider training and qualifications) from skilled nursing services in the State plan. Under the state plan, skilled nursing is intended for short-term, intermittant treatment of acute conditions or exacerbation of a chronic condition. The waiver skilled nursing service is used for treatment of chronic, stable,long-term conditions that cannot be delegated or self-directed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Skilled Nursing may not may not be duplicative of any other waiver service.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

■ Relative

■ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse
Individual	Licensed Pratical Nurse
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service Service Name: Skilled Nursing

Provider Category:

Individual 🔻

Provider Type:

Registered Nurse **Provider Qualifications**

License (specify):

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Stilet Standard (speetyy).

Verification of Provider Qualifications

Entity Responsible for Verification:

State or AAA prior to contracting

Frequency of Verification:

Prior to contracting and on individual license renewal schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service Service Name: Skilled Nursing

Provider Category:

Individual 🔻

Provider Type:

Licensed Pratical Nurse

Provider Qualifications

License (specify):

Licensed under Chapter 18.79 RCW and Chapter 246-840 WAC

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

State or AAA

Frequency of Verification:

Prior to contracting and per individual licensing schedule

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

License under Chapter 70.127 RCW

Certificate (specify):

Other Standard (specify):

Individual RNs and LPNs employed by the agency must be licensed under Chapter 18.79 RCW and Chapter 246-840 WAC.

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon contracting and per licensing schedule

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.

Service is not included in the approved waiver.

Service Definition (Scope):

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

This service also includes maintainence and upkeep of items covered under the service and training for the participant/caregivers in the operation and maintainance of the item. Training may not duplicate training provided in other waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service provided only as identified in the participant's CARE assessment and plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual.

Service Delivery Method (check each that applies):

Ī	Partici	pant-di	rected	as sp	pecified	in	App	endix	E

Provider managed

Specify whether the service may be provided by (check each that applies):

- **■** Legally Responsible Person
- Relative
- □ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Equipment and Supply Contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider	Category:
----------	-----------

Agency ▼

Provider Type:

Medical Equipment and Supply Contractor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Have a State contract as a Title XIX vendor

Verification of Provider Qualifications

Entity Responsible for Verification:

State/AAA

Frequency of Verification:

Upon purchase of specialized equipment and as necessary thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i	Service Type:
	Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

- © Service is included in approved waiver. There is no change in service specifications.
- © Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Deliver	v Method	(check eac	h thai	t appli	ies)	1:
-----------------	----------	------------	--------	---------	------	----

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- **■** Legally Responsible Person
- **■** Relative
- □ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Volunteer
Individual	Taxi
Individual	Individual Provider
Agency	Public Transit

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service Service Name: Transportation
Provider Category:
Individual 🔻
Provider Type:
Volunteer
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify):
Standards are the same as those applied to vendors who provide access to state plan medical services
Verification of Provider Qualifications Entity Responsible for Verification:
State/AAA
Frequency of Verification:
Prior to contracting
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service
Service Name: Transportation
Provider Category:
Individual 🔽
Provider Type:
Taxi
Provider Qualifications License (consist):
License (specify):
Certificate (specify):
Other Standard (specify):
Standards are the same as those applied to vendors who provide access to state plan medical services Verification of Provider Qualifications
Entity Responsible for Verification:
State or AAA
Frequency of Verification:
Prior to contracting
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Comica Tuna. Other Comica
Service Type: Other Service Service Name: Transportation
Provider Category:
Individual ▼
Provider Type:
Individual Provider

Provider Qualifications License (specify):
Election (operator)
Certificate (specify):
Other Standard (specify): Standards are the same as those applied to vendors who provide access to state plan medical services
Verification of Provider Qualifications Entity Responsible for Verification: State or AAA
Frequency of Verification: Prior to contracting
Appendix C: Participant Services
C-1/C-3: Provider Specifications for Service
Service Type: Other Service Service Name: Transportation
Provider Category:
Agency -
Provider Type:
Public Transit
Provider Qualifications
License (specify):
Certificate (specify):
Other Standard (specify): Standards are the same as those applied to vendors who provide access to state plan medical services
Verification of Provider Qualifications Entity Responsible for Verification: State/AAA

Frequency of Verification:

Prior to contracting

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (select one):
 - Not applicable Case management is not furnished as a distinct activity to waiver participants.
 - Applicable Case management is furnished as a distinct activity to waiver participants. Check each that applies:
 - As a waiver service defined in Appendix C-3. Do not complete item C-1-c.
 - As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete
 - As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.

- As an administrative activity. Complete item C-1-c.
- **c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management is provided by State case managers and Area Agency on Aging case managers as an administrative activity.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):
 - No. Criminal history and/or background investigations are not required.
 - © Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The Background Check Central Unit is responsible for conducting the background check.

a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted;

Personal care providers (agency or individual), case managers, LPN, RN, Nursing Assistant, Certified Dietician, Physical Therapist, Occupational Therapist, and any waiver provider who has unsupervised access to a vulnerable adult.

(b) the scope of such investigations (e.g., state, national); and,

The State's background check includes a comprehensive criminal history information including aliases, as well as information about persons who are on a state registry for findings of abuse, neglect, abandonment or exploitation against a minor or vulnerable adult (state). If the provider has lived in Washington State less than three years, a fingerprint-based check. {national}

(c) the process for ensuring that mandatory investigations have been conducted.

The entity originally requesting the background check receives a letter outlining the findings of the background check from the Background Check Central Unit. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening.

- **b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):
 - No. The State does not conduct abuse registry screening.
 - Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- a)The Background Check Central Unit maintains the abuse registry and conducts screenings against the registry.
- (b)Personal care providers (agency or individual), case managers, LPN, RN, Nursing Assistant, Certified Dietician, Physical Therapist, Occupational Therapist, and all other waiver providers who have unsupervised access to a vulnerable adult
- (c) The entity originally requesting the background check receives a letter outlining the findings of the background check from the Background Check Central Unit. This letter is used to determine whether a potential provider is cleared for contracting. Contracts cannot be executed and providers cannot be paid without evidence of complete background check which includes abuse registry screening.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act. Select one:
 - No. Home and community-based services under this waiver are not provided in facilities subject to §1616 (e) of the Act.
 - © Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
 - i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Boarding Home	
Adult Family Home	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Adult Family Homes are typical homes located in residential neighborhoods which provide a homey atomsphere to residents. Residents may have vistors at times convenient to the individual and privacy for visitation is available. Residents have either private rooms or share a room with one other individual and may have their own possessions, clothing and personal items. Small dining rooms are available for meals. Homes are located with access to community resources and activities.

Assisted Living (AL) services are provided in private apartments with an emphasis on privacy and personal choice. A kitchen is available in the apartment and residents may have visitors at times of their convenience. AL residential settings are located with access to community resources and activities.

Individuals receiving Enhanced Residential Care services may have private rooms or share a room with no more than one other person and may have their own possessions, clothing and personal items. Meals are eaten in a dining room and snacks are available to participants. Participants are ensured access to individually preferred personal items. Visitors may be received at times convenient for the individual and privacy is provided for visitation. Space and supplies are provided for participants to engage in activities that are consistent with the participant's interests, abilities, and preferences. Service settings have access to community resources and activities.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Boarding Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nurse Delegation	
Skilled Nursing	V
Adult Day Care	
Caregiver/Recipient Training Services	~
Home Health Aide	
Personal Care	~
Community Transition Services	
Transportation	
Personal Emergency Response	
Home Delivered Meals	
Environmental Accessibility Adaptations	
Managed Care Option - Capitated	
Specialized Medical Equipment and Supplies	✓

Facility Capacity Limit:

7 or more residents - capacity is based on the building standards of the physical facility

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	<u>~</u>
Physical environment	▽
Sanitation	<u>~</u>
Safety	<u> </u>
Staff: resident ratios	
Staff training and qualifications	<u>~</u>
Staff supervision	
Resident rights	<u>~</u>
Medication administration	<u>~</u>
Use of restrictive interventions	<u>~</u>
Incident reporting	<u>~</u>
Provision of or arrangement for necessary health services	<u>~</u>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

ADSA does not have specified ratios for staff to resident staffing. Outlined in WAC 388-78A-2450, is the standard that each boarding home must provide sufficient, trained staff to:

- (a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;
- (b) Maintain the boarding home free of safety hazards; and
- (c) Implement fire and disaster plans.

This means that boarding homes have to meet all resident needs, regardless of whether the need was specifically assessed or not. Determinations about staffing are reviewed during an inspection or a complaint investigation. The investigator makes a determination based on what "did" or "did not" happen for the resident.

There is no regulatory language that states specific requirement around the issue of staff supervision, but there is a basic assumption in all of ADSA's licensing standards that the licensee will supervise their staff and that resident needs will be met.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Family Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Nurse Delegation	<u> </u>
Skilled Nursing	<u> </u>
Adult Day Care	
Caregiver/Recipient Training Services	<u> </u>
Home Health Aide	
Personal Care	V
Community Transition Services	
Transportation	
Personal Emergency Response	
Home Delivered Meals	
Environmental Accessibility Adaptations	
Managed Care Option - Capitated	
Specialized Medical Equipment and Supplies	<u> </u>

Facility Capacity Limit:

6

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	<u> </u>
Physical environment	<u>~</u>
Sanitation	<u>~</u>
Safety	<u>~</u>
Staff: resident ratios	
Staff training and qualifications	<u>~</u>
Staff supervision	
Resident rights	<u>~</u>
Medication administration	<u>~</u>
Use of restrictive interventions	<u>~</u>
Incident reporting	<u> </u>
Provision of or arrangement for necessary health services	<u> </u>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Adult Family Home staff requirements are oulined in WAC 388-76-10195. The adult family home must ensure:

- (1) Enough staff is available in the home to meet the needs of each resident if residents are in the home or not, except as per WAC 388-76-10200;
- (2) Staff are readily available to meet resident needs if the home takes the resident out to another location and the resident negotiated care plan does not indicate it is safe for the resident to be left unattended for a specific time period; and
 - (3) All staff are skilled and able to do the tasks assigned to meet the needs of each resident.

In addition to other licensing requirements for staff availability, WAC 388-76-10200 outlines the requirements of the adult family home must to remain available. The AFH must:

- designate an experienced, capable staff member of responding on behalf of the provider or entity representative. They must be available by phone or page at all times including when no residents are present in the home; and when the provider entity representative and residents are on vacation or away from the home.
- Give residents the telephone or pager number for the contact required
- Ensure the provider, entity representative or resident manager is readily available to each resident; Residents' representatives; Caregivers; and Authorized state staff.

This means that Adult Family Homes have to meet all resident needs, regardless of whether the need was specifically assessed or not. Determinations about staffing are reviewed during an inspection or a

complaint investigation. The investigator makes a determination based on what "did" or "did not" happen for the resident.

There is no regulatory language that states specific requirement around the issue of staff supervision, but there is a basic assumption in all of ADSA's licensing standards that the licensee will supervise their staff and that resident needs will be met.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. Select one:
 - No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
 - Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:
 - The State does not make payment to relatives/legal guardians for furnishing waiver services.
 - The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

A participant may choose a relative/legal guardian to provide the service of personal care except a spouse/married or legally separated. (This waiver is for adults only) Providers, regardless of relationship to the

participant, must meet all specified qualifications and must have a properly executed provider agreement. When the participant is unable to supervise providers, case managers are instructed to identify a third party to provide supervision and monitor the best interests of the participant (long term care manual chapter 3).

Accountability systems regarding receipt and payment for waiver services provided by non-relative providers are applicable to relative providers.

Payment for services is processed by the Department. DSHS maintains data on the waiver participant including participant name, birth date, social security number and case number. The participant data is associated with the provider name, provider payment identification number, waiver service begin and end dates, rates and authorization information. An invoice from an authorized provider is the basis for payment of waiver services which have been provided. Each service is shown on an invoice one time each month it was authorized as the month ends. A service will not be shown on an invoice a second time unless the case manager re-authorizes payment. The signed invoice is verification the service has actually been provided. Payments are made directly to the service provider

Payment for services identified in the care plan will be authorized when the following are satisfied:

- 1. Categorical relatedness and financial eligibility are approved
- 2. The participant is eligible for nursing facility level of care and is, or likely to be institutionalized
- 3. The care plan has been approved by the participant and consultant
- 4. The service provider is qualified

As with providers who are not related to the participant, per WAC 388-71-0551, the department or contracted AAA may take action to terminate an individual provider's contract if the provider's inadequate performance or inability to deliver quality care is jeopardizing the participant's health, safety, or well-being. Examples of circumstances indicating jeopardy to the client could include, without limitation:

- (1) Domestic violence or abuse, neglect, abandonment, or exploitation of a minor or vulnerable adult;
- (2) Using or being under the influence of alcohol or illegal drugs during working hours;
- (3) Other behavior directed toward the client or other persons involved in the client's life that places the client at risk of harm;
- (4) A report from the client's health care provider that the client's health is negatively affected by inadequate care;
 - (5) A complaint from the client or client's representative that the client is not receiving adequate care;
 - (6) The absence of essential interventions identified in the service plan, such as medications or medical supplies

	supplies
0	Other policy.

Specif	y
--------	---

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Individual providers of personal care who meet published qualifications can enroll any time. Participants who use individual providers of personal care services can choose their provider. If a participant chooses a provider who is not enrolled, ADSA and AAA case managers assist the proposed provider with enrollment by providing background checks, training and contracting. Any willing and qualified provider has the opportunity to enroll any time. The state maintains an open registry of qualified providers. Qualifications are published in WAC and are available to the public via web access and by hard copy upon request.

For all other waiver services, the state establishes qualifications and offers the opportunity for any willing provider to demonstrate qualifications and enroll via a periodic issuance of Requests for Qualifications. Any provider who meets qualifications and is willing to contract must be contracted per policy. If there are access problems identified in any area of the state, the local area must immediately seek out and enroll qualified providers to address the access

problem.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

- i. Sub-Assurances:
 - a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percent of AFH providers that meet licensing requirements at time of initial Medicaid contracting N=Adult Family Home providers that initially meet licensing requirements at contracting D=All Adult Family Home providers contracted

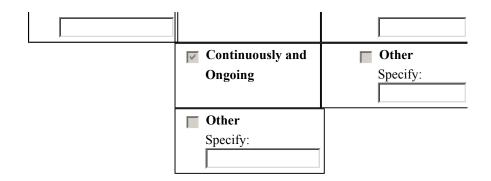
Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
Operating Agency	™ Monthly	☐ Less than 100% Review
Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:



Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	™ Weekly
Operating Agency	✓ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

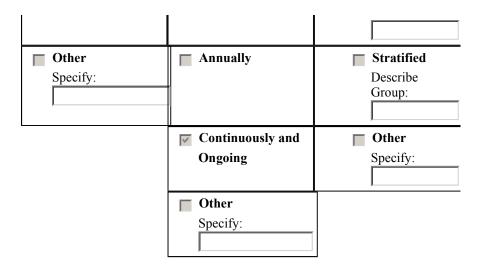
The percent of AFH providers that continue to meet licensing requirements at time of Medicaid contract renewal N=Adult Family Home providers that continue to meet licensing requirements at contract renewal D=All Adult Family Home providers contracted

Data Source (Select one):

Other

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	☐ Weekly	№ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review
□ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =



Data Aggregation and Analysis:		
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	
▼ State Medicaid Agency	☐ Weekly	
☐ Operating Agency	✓ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	Annually	
	Continuously and Ongoing	
	Other Specify:	

The percent of Enhanced Adult Residential Care (EARC) providers that initially meet licensing requirements at time of Medicaid contract N=The number of EARC providers that initially meet licensing requirements at time of contracting **D=All EARC providers contracted**

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data

Responsible Party for	Frequency of data	Sampling Approach
data		(check each that applies):
▼ State Medicaid	 Weekly	№ 100% Review
Agency		
☐ Operating Agency	■ Monthly	Less than 100%
		Review

Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
☐ Operating Agency	✓ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

The percent of Enhanced Adult Residential Care (EARC) providers that continue to meet licensing requirements at time of Medicaid contract renewal N=EARC providers that continue to meet licensing requirements at time of contract renewal D=All EARC providers contracted

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data

data	collection/generation (check each that applies):	Sampling Approach (check each that applies):

State Medicaid Agency	□ Weekly	№ 100% Review
Operating Agency	■ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

The percent of Assisted Living (AL) providers that initially meet licensing requirements at time of Medicaid contract N=AL providers that initially meet licensing requirements at initial contracting D=All AL providers contracted

Data Source (Select one):	
Other	
If 'Other' is selected, specify:	
Administrative Data	

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
Operating Agency	 Monthly	Less than 100% Review
Sub-State Entity Other Specify:	☐ Quarterly ☐ Annually	Representative Sample Confidence Interval = Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	,

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	✓ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

The percent of Assisted Living (AL) providers that continue to meet licensing requirements at time of Medicaid contract renewal N=AL providers that continue to meet licensing requirements at time of contract renewal D=All AL providers

contracted

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
Operating Agency	™ Monthly	Less than 100% Review
■ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Specify:	

Data Aggregation and Analysis.

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	™ Weekly
Operating Agency	✓ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify:

1	

The percentage of waiver service providers that require licensure and/or certification that initially meet ADSA contract standards. Numerator: All waiver service providers that required licensure and/or certification initially meet contract standards Denominator: All waiver service providers that require licensure and/or certification

Data Source (Select one): **Record reviews, on-site** If 'Other' is selected, specify:

If 'Other' is selected, specif		П
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies).
State Medicaid Agency	☐ Weekly	☑ 100% Review
☐ Operating Agency	™ Monthly	Less than 100% Review
■ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
▼ Other Specify: AAA	□ Annually	Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☑ State Medicaid Agency	□ Weekly
☐ Operating Agency	 ☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	✓ Annually

Continuously and Ongoing
Other
Specify:

The percentage of waiver service providers that require licensure and/or certification that continue to meet ADSA contract standards. Numerator: All waiver service providers that required licensure and/or certification continue to meet contract standards Denominator: All waiver service providers that require licensure and/or certification

Data Source (Select one): Record reviews, off-site
If 'Other' is selected specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
☐ Operating Agency	 Monthly	☐ Less than 100% Review
□ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
Specify: AAA	☐ Annually	Describe Group:
	Continuously and Ongoing	Other Specify:
	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
V State Medicaid Agency	☐ Weekly

☐ Operating Agency	 Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	✓ Annually	
	Continuously and Ongoing Other Specify:	
	Specify.	

The percent of Home Care Agency providers that meet licensing requirements at time of initial Medicaid contracting N=Home Care Agency providers that meet licensing requirements at initial contracting D=All Home Care Agency providers contracted

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify

If 'Other' is selected, specif	y:	
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
☐ Operating Agency	™ Monthly	☐ Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =
Other Specify: AAA	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data A	Aggregation	and A	Analysis:

Responsible Party for data Frequency of data aggregation and

aggregation and analysis (check each that applies):	analysis (check each that applies):
☐ State Medicaid Agency	□ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify: AAA	Annually
	Continuously and Ongoing
	Other Specify:

The percent of Home Care Agency providers that meet continue to meet licensing requirements at time of Medicaid contract renewal N=Home Care Agency providers that continue to meet licensing requirements at time of contract renewal D=All Home Care Agency providers contracted

Data Source (Select one): **Record reviews, off-site**

If 'Other' is selected, specif	·y:	
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	□ Weekly	№ 100% Review
Operating Agency	™ Monthly	Less than 100% Review
■ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify: AAA	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Source (Select one):

Record reviews, on-site If 'Other' is selected, specify	y:	
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
Operating Agency	™ Monthly	Less than 100% Review
■ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
Specify: AAA	 Annually	Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify: AAA	✓ Annually
	Continuously and Ongoing
	Other Specify:

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

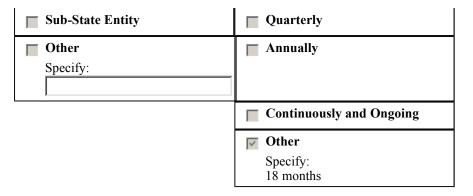
Performance Measure:

The percent of individual providers that meet waiver requirements N=# of contracted individual providers that meet waiver requirements D=# of contracted individual providers

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify: **Responsible Party for** Frequency of data Sampling Approach data collection/generation (check each that applies): collection/generation (check each that applies): (check each that applies): ■ Weekly **■ 100% Review ▼** State Medicaid Agency **■** Monthly **▼** Less than 100% Operating Agency Review **■** Sub-State Entity Quarterly V Representative Sample Confidence Interval = 5% □ Other Annually **■ Stratified** Describe Specify: Group: □ Other Continuously and **Ongoing** Specify: **Other** Specify: 18 months

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly



c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percentage of individual providers providing services that meet training requirements Numerator: Number of Individual Providers providing services that meet training requirements Denominator: Number of Individual Provider providing services

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	☐ 100% Review
Operating Agency	 ■ Monthly	Less than 100% Review
□ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:

☐ Continuously and Ongoing	Other Specify:
Specify: 18 months	

Data Aggregation and Analysis:

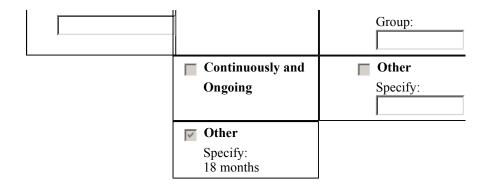
Data Aggregation and Analysis:		
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	
▼ State Medicaid Agency	☐ Weekly	
☐ Operating Agency	☐ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	☐ Annually	
	Continuously and Ongoing	
	Other Specify: 18 months	

Performance Measure:

Percent of Home Care Agency providers that meet training requirements Numerator: Number of Home Care Agency providers reviewed that meet training requirements Denominator: Number of Home Care Agency providers reviewed

Data Source (Select one): Record reviews, off-site
If 'Other' is selected, specify:

If Other is selected, specif	<u>y:</u>	
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	☐ 100% Review
☐ Operating Agency	™ Monthly	▼ Less than 100%
		Review
■ Sub-State Entity	☐ Quarterly	✓
		Representative Sample Confidence Interval = 5%
Other	☐ Annually	☐ Stratified
Specify:		Describe



Data Aggregation and Analysis:	1
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

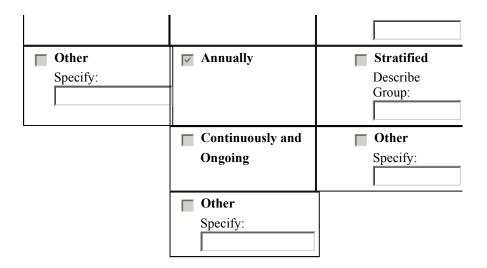
Percent of RNs providing Nurse Delegation that have met training requirements Numerator: Number of RNs reviewed that provide nurse delegation and have met training requirements Denominaotr: Number of RNs reviewed that provide nurse delegation

Data Source (Select one): Record reviews, off-site

If 'Other' is selected, specify:

		Sampling Approach (check each that applie
	(check each that applies):	
▼ State Medicaid	 Weekly	▼ 100% Review

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
State Medicaid Agency	☐ Weekly	№ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review
■ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =



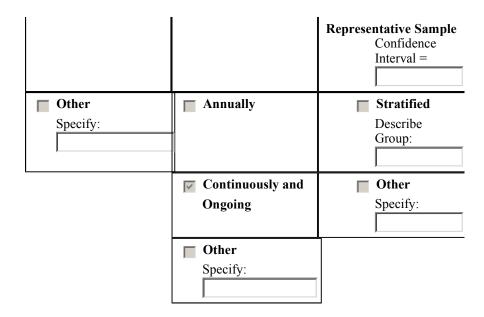
Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Percent of boarding homes that meet training requirements Numerator: Number of boarding homes that meet training requirements Denominator: Number of boarding homes

Data Source (Select one): Record reviews, off-site

If 'Other' is selected specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	№ 100% Review
☐ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	



Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Percent of adult family homes that meet training requirements Numerator: Number of adult family homes that meet training requirements Denominator: Number of adult family homes

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	☐ Weekly	№ 100% Review
☐ Operating Agency	☐ Monthly	Less than 100%

		Review
□ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

Percent of adult family homes that completed specialty training Numerator: Number of adult family homes that completed specialty training Denominator: Number of adult family homes that care for waiver residents with dementia, mental health, or developmental disabilities

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

data collection/generation	Sampling Approach (check each that applies):
(check each that applies):	

State Medicaid Agency	☐ Weekly	☐ 100% Review
Operating Agency	™ Monthly	Less than 100% Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	☐ Continuously and Ongoing	Other Specify:
	Other Specify: 18 monthls	

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
 - -Contracts for all waiver providers are maintained in a central database. Contract status is updated on a daily
 - -Adult Family Homes and Boarding Homes are monitored by the State every 18 months. Inspection reports, statement of deficiencies, and record reviews are used to verify compliance.
 - -Nurse delegators are contracted for two years after verification that all requirements are met. To ensure that all contracts are current and up to date, all contracts are renewed at the same time on a two year cycle.

- Agency providers are monitored by the Area Agency on Aging (AAA). Reports are provided to the Medicaid Agency (ADSA) annually. Comprehensive contract monitoring is conducted every other year. On alternate years, a focus monitoring is conducted. The Medicaid Agency reviews reports on an ongoing basis that are provided by the AAA to verify that monitoring and remediation of providers are occurring.
- Nursing Assistant Certified (NAC) and Nursing Assistant Registered (NAR) must complete required training to be able to perform delegated tasks. The State (Department of Health) maintains a registry system which verifies contract status.
- Other waiver service contracts (Home delivered meals, Personal Emergency Response System, etc.) are monitored by AAA which is verified by the State.
- Individual providers must meet all requirements prior to contracting. Contracts are maintained in the State's contract database and monitored by the AAA.
- Waiver participants that choose to self direct their personal care, hire, train and supervise qualified providers are free to terminate the provider's employment and select new providers. Individual and agency providers must complete Fundamentals of Care Giving Orientation within 14 days of beginning employment. Revised Fundamentals of Caregiving must be completed within 120 days of employment. Note: An IP may take the Modified Fundamentals of Caregiver Self-Study course in lieu of the full Fundamentals course if the IP documents successful completion as an RN, LPN, or NAC, PT, OT, or a Medicare certified home health aide. Continuing education of 10 hours must be completed each calendar year following the Fundamental training. Required training is outline in WAC 388-71-05805 through WAC 388-71-05830, for an individual provider or home care agency worker who will be performing a nurse delegated task. Payment is terminated if the IP/agency worker does not complete the required training prior to providing a delegated task.
- Each HCS/AAA supervisor monitors all the individual providers for four randomly selected participants per worker per year. Provider contract and training compliance is also monitored through the DSHS /central contracts database. The QA unit monitors a statistically valid sample of provider files/qualifications. Monitoring includes verification that:
- o Background checks are completed and passed
- o Provider contract is completed and valid
- o Required training was completed within the timeframes indicated
- Providers subject to licensing or certification are valid at the time of contract renewal and per individual licensing or certification schedule.
- A home visit is conducted within 30 days of an initial transfer to in-home case management to ensure the plan of care is in place, services are being implemented, the provider is adhering to requirements, and no further changes are needed.
- Face-to-face monitoring and verification occurs at the annual review and/or if there is a significant change. A minimum number of other contacts is specified based on the level of case management to verify that the plan is being appropriately implemented and to review a sampling of timesheets.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When a residential provider does not meet licensing/certification requirements RCS implements corrective action which may include technical assistance, sanctions, and/or termination. Based upon findings from onsite inspections areas of non-compliance are evaluated for scope and severity. Enforcement remedies are

action which may include technical assistance, sanctions, and/or termination. Based upon findings from onsite inspections, areas of non-compliance are evaluated for scope and severity. Enforcement remedies are immediate and based upon real or potential negative impact on residents living in the home. Trends are discussed at RCS management team meetings and outcomes and actions are discussed and prioritized. On a yearly basis, areas of most frequent citation during that year are evaluated. Identified issues often determine where additional policy clarification is required or training is needed.

Case managers have the ability to terminate contracts for individual providers if qualifications are not sustained.

AAAs provide technical assistance if standards are not met for other provider contracts they manage. Failure to make required changes can lead to contract termination.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly

Operating Agency	■ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify: AAA	Annually	
	Continuously and Ongoing	
	Specify: 18 months	

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No
 No
 ■ No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

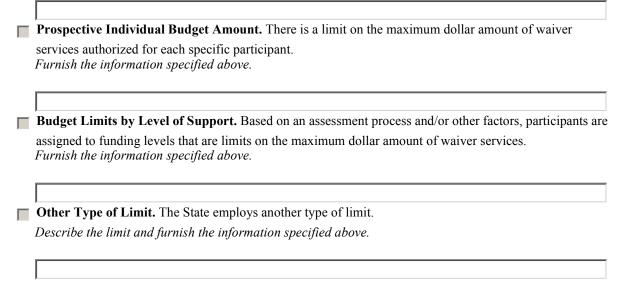
Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- **a.** Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).
 - Not applicable The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
 - Applicable The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (check each that applies)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. Furnish the information specified above.



Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Comprehensive Assessment Reporting Evaluation (CARE) Plan

- **a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):
 - Registered nurse, licensed to practice in the State
 - Licensed practical or vocational nurse, acting within the scope of practice under State law
 - ☐ Licensed physician (M.D. or D.O)
 - Case Manager (qualifications specified in Appendix C-1/C-3)
 - **▼ Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

RN: licensed under Chapter 18.79 RCW

Case Manager:

In addition to meeting the following minimum qualifications, staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Service plans are developed by case managers who can be a Registered Nurse (licensed in the State)or a Social Worker. For social workers, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Worker 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Worker 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

Job classification discriptions are available from the Medicaid agency.

Social Worker.

Specify qualifications:

□ Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards. Select one:
 - © Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
 - Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Case managers review the "Client's Rights and Responsibilities (DSHS 16-172)" document with clients that outlines their right to participate in the development of their plan of care and ensure that their preferences and the services they wish to receive are included in their plan of care. The Client's Rights are:

As a client of Aging and Disability Services Administration, you have a right to:

- Be treated with dignity, respect and without discrimination;
- Not be abused, neglected, financially exploited, abandoned;
- Have your property treated with respect;
- Not answer questions, turn down services, and not accept case management services you do not want to receive. However, it may not be possible for Aging and Disability Services Administration to offer some services if you do not give enough information;
- Be told about all services you can receive and make choices about services you want or don't want;

- Have information about you kept private within the limits of the laws and DSHS regulations;
- Be told in writing of agency decisions and receive a copy of your care plan;
- Not be forced to answer questions or do something you don't want to;
- Talk with your social service worker's supervisor if you and your social service worker do not agree;
- Request a fair hearing;
- Have interpreter services provided to you free of charge if you cannot speak or understand English well;
- Take part in and have your wishes included in planning your care;
- Choose, fire, or change a qualified provider you want; and
- Receive the results of the background check for any individual provider you choose.

The "Medicaid and Long Term Care Services for Adults (DSHS 22-619)" brochure is given to all new clients at initial assessment. This document outlines Medicaid eligibility and long term care services available.

Service plan development always includes the client and their legal representative (if applicable). Clients may include any other individuals of their choice to participate. ADSA encourages clients to include family and other informal supports as appropriate to the client's situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

ADSAs process that is used to develop the participant-centered service plan, includes:

(a) Who develops the plan, who participates in the process, and the timing of the plan;

The case manager develops the plan of care along with the client and their legal representative (if applicable). The client may include any other person(s) of their choosing including family and other formal and informal supports. The initial plan of care must be completed within 30 days of the date of the referral. The plan of care is updated at least annually and when significant change occurs. A significant change assessment is a face-to-face interview conducted when there has been a change for better or worse in the client's cognition, ADLs, mood and behaviors, or medical condition.

(b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status;

Case managers conduct assessments using the CARE automated assessment tool. CARE leads the case manager and client systematically though a series of assessments covering multiple life domains. Assessment items are based on the Minimum Data Set (MDS) and all areas include client preferences, limitations and caregiver instructions.

Assessment areas include demographics, collateral contacts, formal and informal supports, caregiver status which includes the Zerit burden scale to assess provider burden, behavioral issues, psychosocial and legal issues. Medical assessment includes diagnoses, ability to manage medications, treatments, both skilled and unskilled, mobility and toileting.

Care assesses indicators of medical risk including number of hospitalizations, skin breakdown, history of routine and preventive medical care, medication regimen and multiple diagnoses.

CARE Screens and assessment elements:

- -Client demographics including: collateral Contacts, Caregiver Status, Financial eligibility, Employment status and goals.
- -Medical and health status: Current Medications and Medication Management, Diagnoses, Treatments both skilled and unskilled, Indicators of risk such as recent hospitalizations, skin problems, pain, lack of preventive care (mammograms, PSA, Colonoscopy, etc.), significant change in self sufficiency, Communication skills and resources, Ability to use the phone, vision, speech, and hearing abilities, mobility and history/risk of falls.
- -Psychosocial assessment: MMSE, Memory, Each current or past behavior and successful interventions, depression, Suicide risk, Sleep patterns, Relationships and Interests, Decision Making, Client goals, Alcohol, tobacco and substance abuse.
- -Legal Issues Any legal matters concerning the client including: Risk of abuse, neglect, and/or exploitation, No contact or protection orders, Less restrictive order, Guardianship, Power of Attorney, Advanced Directives, Divorce proceedings, Eviction, Involuntary commitment, Lawsuits, Parole or probation, Pending civil or criminal proceedings.
- -Activities of Daily Living including: Toileting, Nutritional/Oral status, Bathing, Dressing, Personal Hygiene, Household Tasks, Transportation, Shopping, Wood Supply if wood is the sole source of heating or cooking, Housework, Assessing for environment modifications and/or assistive equipment.
- (c) How the participant is informed of the services that are available under the waiver;

Case managers provide and review with all individuals interested in services the Medicaid and Long-Term Care Services for Adults brochure (DSHS 22-619X). This booklet outlines the services, resources, and options available through ADSA including options under the COPES Waiver. This booklet includes several links to information about services and resources for individuals who have internet access.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences;

CARE auto generates the results of the assessment including all identified needs (including health care, equipment, and environment needs), client goals, and preferences into a plan of care. The plan of care will show as "incomplete" until the case manager and client have completed all sections of the assessment and addressed all identified needs. A nursing referral may be recommended or required based on certain data elements or combination of data elements (critical indicators) that were selected in the assessment. Potential critical indicators include: Unstable/potentially unstable diagnosis, caregiver training required, medication regimen affecting plan of care, nutritional status affecting plan of care, immobility risks affecting plan of care, past or present skin breakdown, and risk of skin breakdown.

The plan of care is reviewed with the client to assure that their goals and preferences are included and that the plan meets their needs. Client consent is required before the plan of care is considered complete and can be implemented.

(e) How waiver and other services are coordinated;

During the assessment process, case managers obtain the client's permission to collect information and coordinate service planning with the client's primary care provider and other service systems such as mental health and/or alcohol and substance abuse. When considering how care needs are being met, the care plan takes into account services being received from allied systems. For clients who have very complex needs or who are involved in multiple systems, cross systems case staffing may be employed.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan;

The case manager has primary responsibility for implementing and monitoring the care plan. The case manager reviews the plan of care with providers prior to implementation to answer any questions and ensure the care giver understands and is able to provide the care outlined in the plan of care. The client and his/her family are encouraged to contact the case manager immediately if there are problems with the plan. As part of annual plan of care monitoring, case managers are required to make at least three additional contacts following the initial/annual face-to-face visit for in-home recipients. For residential recipients, frequency of contacts are based on the recipients care needs, cognition, emotional, psychiatric, behavioral problems, and his/her support system.

Care plans are also routinely monitored by the quality assurance process and a regular schedule of supervisor reviews.

(g) How and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Care plans are updated annually or when significant change occurs. Significant change is defined as a reported significant change, for better or worse, in the client's cognition, mood/behavior, ADL's or medical condition. Annual updates and significant change assessments are completed face-to-face at the client's home. Interim updates are made as necessary when there are changes in providers, schedules etc.

(h) How the participant engages in and/or directs the planning process.

ADSA policy stipulates that the client is the primary source of assessment information. The client and their legal representative (if applicable), along with the case manager develop the plan of care. The client may include any other person(s) of their choosing including family and other formal and informal supports. The client has free choice of qualified providers and employer authority for personal care services. Within the parameters of the program, client's can choose the services that will best meet their needs.

References:

- CARE, Chapter 3, Long Term Care Manual
- Case Management, Chapter 5, Long Term Care Manual
- Personal Care, Chapter 7, Long Term Care Manual
- 388-106 WAC, Long Term Care Services

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Risk assessment is incorporated directly into service planning. CARE assessments identify clients who are potentially or currently at risk. Risk assessment screens cover common areas of risk such as: mental and physical health, medication use and management, nutrition, behaviors, personal safety, and environment. CARE creates critical indicators based on certain data elements or combination of data elements identified by the case manager and client. These critical indicators require the case manager to address each element based on the level of risk and client choice. These indicators include: Unstable/potentially unstable diagnosis, Caregiver training required, Medication regimen affecting plan of care, Nutritional status affecting plan of care, Immobility risks affecting plan of care, and past or present skin breakdown.

Exception to Rule (ETR) requests may be submitted if the hours/daily rate generated by the CARE algorithm does not meet the participant's direct and ADL care needs. Managers of statewide HCS programs conduct team review of ETR's weekly. ETR approvals are based on the clinical characteristics and specific care needs of the participant.

Back up plans are discussed and planned for during the assessment process. The case manager assists with alternatives such as using a Home Care Agency or locating a back up provider in the provider Registry.

Every plan of care must include an evacuation plan. If evacuation without assistance is difficult or impossible the case manager and client discuss the risks involved and possible outcomes. The case manager discusses long term care settings that may meet the individual's needs and reduce risk. If the individual chooses to stay at home, the case manager documents the client's decision.

Appendix D: Participant-Centered Planning and Service Delivery

D-1. Set the I fall Detelopment (o of o)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Clients are given free choice of all qualified approved providers of each service included in the plan of care. Case managers assist clients in locating qualified providers. The case manager will work with the client to qualify a provider when the client wishes to hire and supervise a personal care provider of their choice. All providers must meet the qualifications specified in Appendix C of this waiver.

The case manager can help the client locate an IP through the State's existing IP registry. If the client has computer access, he/she may access the IP registry directly. The registry allows for access to information about available IP's in a geographic area who are interested in providing in-home personal care services.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

ADSA is an administration within DSHS, the State Medicaid Agency. The individual case manager is an employee of ADSA or the Area Agency on Aging. ADSA determines client eligibility and requires the use of the department's electronic assessment and service planning tool. ADSA case managers directly authorize all initial service plans and conducts quality assurance activities on all service plans. ADSA has direct electronic access to all service plans.

A statewide random sample of service plans is reviewed by the ADSA quality assurance unit on an eighteen month cycle. The sample size is calculated using a statistical valid method to arrive at a targeted confidence level and confidence intervals.

In addition to review of electronic service plans, the ADSA Quality Assurance unit conducts on-site and home visits to assess consumer satisfaction and the accuracy and quality of service plans.

Quality assurance processes may result in corrective actions, adjustments to training curriculum, policy clarifications, forms revision, WAC revisions and targeting criteria for the next review cycle.

Full details regarding the frequency of reviews, review methodology, and roles and responsibilities are outlined in Appendix H.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h.	Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess
	the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the
	review and update of the service plan:

ne appropr	riateness an	d adequacy	of the serv	rices a	s participant needs	change.	Specify the	minimum	schedule i	for the
eview and	update of	the service pl	lan:							
C -					_					

0	Every three	months	or more	frequently	when	necessary
---	-------------	--------	---------	------------	------	-----------

- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary

Other	schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):
 - **▼** Medicaid agency
 - Operating agency
 - Case manager
 - **Other**

Specify:

Local offices maintain written copies of service plans for three years. Electronic copies of the CARE assessment including service plan are maintained by the Medicaid Agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- **a.** Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.
 - (a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare:

ADSA and AAA Case Managers have primary responsibility for monitoring the implementation of plans of care and client health and welfare. The implementation and monitoring of the plans of care ensure that services are provided as outlined. Case managers adjust plans of care as needed or requested by the client. In addition, ADSA quality assurance activities provide monitoring of service plan implementation.

Providers are bound by contract to notify the case manager when there are changes in the client's condition or needs. Collateral contacts are encouraged to notify the case manager with any concerns.

(b) The monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Case managers are required to have a minimum of three annual contacts with the in-home client in addition to the initial/annual face-to-face visit. For residential recipients, frequency of contacts are based on the recipients care needs, cognition, emotional, psychiatric, behavioral problems, and his/her support system. If a significant change occurs, the case manager is required to make a face-to-face contact. When problems/barriers with services or providers are identified, the case manager works with the client to develop solutions and ensure access to waiver and non-waiver (including health) services and free choice of providers. Back-up plans are reviewed for effectiveness and revised accordingly.

Supervisors/Managers at the local level monitor four case manager's records per year for experienced workers and 50% of new staff to ensure that services are furnished as outlined in the plan of care and are meeting the needs, goals, and preferences of the client. ADSA quality assurance unit monitors at a statewide level a sample of each case manager's files. If problems are identified in individual records, supervisors/case managers are expected to remediate the problems at the individual level. Issues related to health and safety and payment are expected to be addressed immediately or within three working days depending on the situation. Other required corrections are completed and verified within 40 calendar days of the preliminary review.

Aggregate data is collected in/reported from the quality assurance monitoring application. This data is used at the local and state level for system improvement.

Additional monitoring and oversight is provided by established Quality Improvement and Management systems described in Appendix G

A more detailed outline of QA monitoring is in Appendix H

b. Monitoring Safeguards. Select one:

- © Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Service Plan Assurance/Sub-assurances
 - i. Sub-Assurances:
 - a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

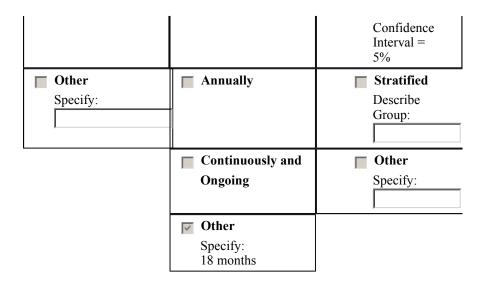
For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

The percentage of Service Plans for waiver participants that address their assessed needs and personal goals by the provision of waiver services or other means. Numerator: Number of service plans reviewed that address all assessed needs and personal goals Denominator: Number of service plans reviewed

Data Source (Select one): **Record reviews, off-site** If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	☐ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review
□ Sub-State Entity	☐ Quarterly	Representative Sample



Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
Sub-State Entity	☑ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify: 18 months

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of service plans completed within 30 days of referral Numerator:

Number of service plans completed within 30 days of referral Denomintor: Number of service plans

Data Source (Select one):
Other
If 'Other' is selected, specify:
Administrative Data

Administrative Data				
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):		
State Medicaid Agency	™ Weekly	№ 100% Review		
☐ Operating Agency	☐ Monthly	Less than 100% Review		
Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =		
Other Specify:	☐ Annually	Stratified Describe Group:		
	▼ Continuously and Ongoing	Other Specify:		
	Other Specify:			

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	☐ Monthly
Sub-State Entity	☐ Quarterly
Other Specify:	✓ Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure: Percent of service plans th number of service plans tl service plans reviewed			ified in the assessment N: leeds D: Number of number o
Data Source (Select one): Record reviews, off-site If 'Other' is selected, specif	·y:		
Responsible Party for data Freque collection		of data eneration that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	☐ Weekly	,	☐ 100% Review
☐ Operating Agency	Month	ly	Less than 100% Review
Sub-State Entity	∏ Quarte	rly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annua	lly	Describe Group:
	Contin Ongoin	uously and	Other Specify:
	Other Specify 18 mon		
Data Aggregation and An Responsible Party for dataggregation and analysis that applies):	ta		of data aggregation and eck each that applies):
State Medicaid Agency		☐ Weekly	,
Operating Agency		Monthl	у
☐ Sub-State Entity		Quarte	rly
Other Specify:		Annual	ly

☐ Continuously and Ongoing



c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of service plans reviewed and updated prior to annual review date Numerator: Number of service plans reviewed and updated prior to annual review date Denominator: Number of service plans reviewed

Data Source (Select one): Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	☐ Weekly	☐ 100% Review
Operating Agency	 Monthly	Less than 100% Review
Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 95%
Other Specify:	☐ Annually	Stratified Describe Group:
	☐ Continuously and Ongoing	Other Specify:
	Other Specify: 18 months	

Data Source (Select one):

Other

If 'Other' is selected, specify Administrative Data	y:		
Responsible Party for data collection/generation (check each that applies):	Frequency of collection/ge (check each to		Sampling Approach (check each that applies):
State Medicaid Agency	☐ Weekly	7	№ 100% Review
Operating Agency	☐ Monthl	y	Less than 100% Review
□ Sub-State Entity	□ Quarte	rly	Representative Sample Confidence Interval =
Other Specify:	Annual	lly	Describe Group:
	Continu Ongoin	uously and g	Other Specify:
	Specify	:	
Data Aggregation and Ana Responsible Party for dat aggregation and analysis that applies):	ta		f data aggregation and eck each that applies):

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope,

Other
Specify:
18 months

Weekly

■ Monthly

Quarterly

Annually

Continuously and Ongoing

▼ State Medicaid Agency

Operating Agency

■ Sub-State Entity

☐ Other

Specify:

amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of service plans where services were delivered as authorized N:Number of service plans where all authorized services were delivered D:Number of service plans reviewed

Data Source (Select one): **Other**

If 'Other' is selected, specify:

Administrative Data

Administrative Data				
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):		
State Medicaid Agency	™ Weekly	№ 100% Review		
Operating Agency	™ Monthly	Less than 100% Review		
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =		
Other Specify:	☐ Annually	Stratified Describe Group:		
	▼ Continuously and Ongoing	Other Specify:		
	Other Specify:			

Data Aggregation and Analysis:	
Responsible Party for data	Frequency of data aggregation and

aggregation and analysis (check each that applies):	analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	✓ Annually
	Continuously and Ongoing
	Other Specify:

e. Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

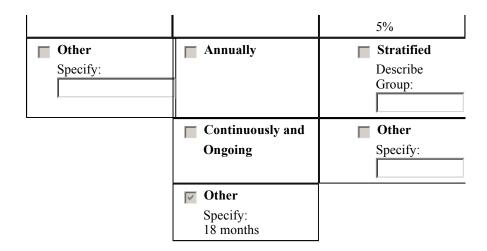
Performance Measure:

Percent of participants that choose between waiver servies and institutional care. Numerator: Number of waiver participants that signed an Acknowledge of Services document Denominator: Number of waiver participants reviewed

Data Source (Select one): **Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	™ Weekly	☐ 100% Review
Operating Agency	™ Monthly	Less than 100% Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =



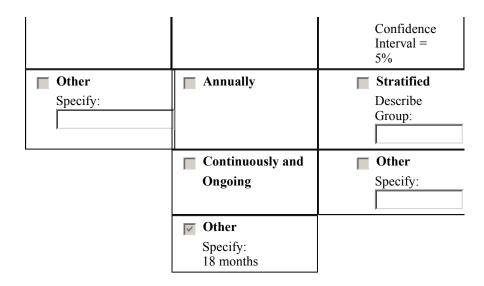
Responsible Party for data aggregation and analysis (check each	Frequency of data aggregation and analysis (check each that applies):
that applies): State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

Performance Measure:

Percent of signed service plans that indicate client choice of provider and services N: Number of signed service plans that indicate client choice of provider and services D: Number of signed service plans

Data Source (Select one): Record reviews, off-site

If 'Other' is selected, specify: **Responsible Party for** Frequency of data Sampling Approach data collection/generation (check each that applies): collection/generation (check each that applies): (check each that applies): **▼** State Medicaid ■ Weekly ☐ 100% Review Agency Operating Agency **Monthly** Less than 100% Review **☐** Sub-State Entity Quarterly Representative Sample



Data Aggregation and Analysis:	-
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify: 18 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

HOW THE CARE PLAN IS DEVELOPED (BACKGROUND)

The plan of care can only be developed using the CARE assessment application. The plan of care is developed with information entered into CARE by the participant and case manager during the assessment process. An algorithm in CARE runs when the assessment is complete to create the plan of care based on the data input by the case manager and participant. CARE tracks identified needs, including needs identified by the participant, and whether providers (formal or informal) are assigned to each identified need. CARE has the case manager address/plan for each topic as he/she moves through the assessment process.

The Service Summary (Plan of Care) identifies areas such as:

- Formal and informal supports, which tasks have been assigned to each and their schedules;
- Participant goals and preferences; and
- Referrals (who will follow through with the referral and when)

HOW DISCOVERY IS DESIGNED AND IMPLEMENTED

ADSA monitors plan of care decisions in several ways:

Local Supervisory Discovery Activities

Each year, social service supervisors/managers monitor four records per experienced worker to ensure the plan of care is reviewed and adjusted, and that all needs (including health and safety and risk factors) and preferences are included in the plan of care and delivered as outlined. For new staff, a minimum of 50% of plans are reviewed during the first six months of employment. Errors in assessment that can lead to an inaccurate plan of care are corrected. Reports for experienced workers can be generated at any time for preliminary action, and annually for statistical analysis.

Statewide ADSA QA Unity Discovery Activities

ADSA QA unit monitors participant plans of care using a statistically valid sample of records statewide on an 18 month review cycle. Preliminary analysis is available annually.

- QA reports are reviewed and corrective action taken on an on-going basis throughout the 18 month review cycle by supervisors and field managers. Case managers are required to take action within specified time frames to address all problems identified in plans of care during the supervisory and QA unit monitoring.
- All participants assessed needs (including health and safety and risk factors) whether or not paid by ADSA, are documented within CARE.
- Evacuation plans are required
- If lack of immediate care would pose a serious threat to the health and welfare of the participant, a backup plan is required.
- QA monitoring assures that all services are delivered in accordance with the service plan, including type, scope, amount, duration, and frequency as specified in the plan of care.

The Quality Assurance application and CARE reports, (QA monitoring data is current at the time monitoring occurred and CARE management reports are in real time), capture the following:

- Needs identified in CARE are adequately addressed in the participants POC
- POC development is participant directed and plans are completed in required time frame
- Participants receive all of the services identified in the POC
- Participants are provided the freedom to choose waiver services, institutional care, and service providers.
- Participants choices are not limited within the parameters of the waiver and choice of providers is adequate to meet participate needs
- Plans are reviewed and revised in response to participant direction or change in needs.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon completion of each record review, the case manager is expected to make necessary corrections. Corrections are verified by either the QA unit or the case management supervisor. The QA unit verifies that required corrections have been made at the individual level within 40 days of the preliminary review and document the verification in the QA monitoring application. Items related to health and safety and payment, require either immediate action or within three working days depending on the situation. Supervisors verify that corrections have been made at the individual level prior to completing the review and document this activity in the QA monitoring application.

Reports and aggregate data are reviewed throughout the year (based on an established review schedule) by individuals who make decisions on what improvements are needed individually or systemically. Regions and AAAs are required to develop corrective action plans within 40 day of receiving their final report. Corrective action plans address any area where proficiency was less than 100%. Draft plans are reviewed by ADSA prior to approval and implementation. Progress reports are produced every six months. Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	™ Weekly
Coperating Agency	Monthly
☐ Sub-State Entity	☐ Quarterly

Cother Specify:	Annually
,	Continuously and Ongoing
	▽ Other
	Other Specify:
	18 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- **©** Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.
- No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- **a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.
 - a) The nature of the opportunities afforded to participants: Participants who choose to receive personal care services from individual providers have employer authority and are

considered the common law employer. Participants' ability to manage their personal care is assessed by the case manager using the CARE assessment tool. Participants who are eligible, based on decision making and cognitive ability as assessed in the CARE assessment tool, may supervise their paid provider. If the participant is unable to always supervise the in-home provider, an informal support person who can assist with the provision of supervision is identified by the participant and the case manager.

Participants who can self direct but choose not to may select an informal support person to assist in direction or may receive personal care services through a Home Care Agency provider.

(b) How participants may take advantage of these opportunities:

All participants have the option of becoming the employer of record for an individual provider. If the waiver recipient chooses to hire an individual provider they are considered the common law employer.

(c) The entities that support individuals who direct their services and the supports that they provide: The Home Care Quality Authority (HCQA) is a small state agency established to improve the quality of long term In-Home services provided by In-Home providers through improved regulations, higher standards, increased accountability, and the enhanced ability of consumers to obtain services. In addition, the Authority was created to encourage stability in the In-Home provider work force. HCQA provides the following services/resources: A referral registry used to connect waiver participants to providers, assistance with hiring and employee management and training for clients on employer functions.

The Aging and Disability Services Administration (ADSA) provides: Training for Individual Providers, Background checks, Contract assistance, Financial Management Services, Case Management services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- **b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one*:
 - **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. Availability of Participant Direction by Type of Living Arrangement. Check each that applies:
 - Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
 - Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
 - The participant direction opportunities are available to persons in the following other living arrangements

specify these fiving arrangements.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Specify these living arrangements:

- **d.** Election of Participant Direction. Election of participant direction is subject to the following policy (select one):
 - Waiver is designed to support only individuals who want to direct their services.
 - The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
 - The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria			

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.
 - (a) Information about participant direction opportunities

Waiver participants are given a booklet entitled "Medicaid and Long Term Care Services for Adults". This document provides the waiver participant with information about being an employer and resources for related skill development; information about the financial management role of DSHS; and information about the role of the Home Care Quality Authority (HCQA). The booklet also discusses the benefits of personal care provided by an Individual provider (self directed) compared to personal care provided by a Home Care Agency (provider directed). (b) The entity or entities responsible for furnishing this information:

The Case Resource Manager/Social Worker is responsible for furnishing the information to the waiver participant.

(c) How and when this information is provided on a timely basis:

Case managers provide information throughout the assessment and service plan development process. The "Medicaid and Long Term Care Services for Adults". booklet is given to the client during service planning. Information is also available on the ADSA internet and through the HCQA.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- **f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*
 - The State does not provide for the direction of waiver services by a representative.
 - The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (check each that applies):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Representatives who direct waiver services may not be paid providers.

The participant identifies a friend, family member, neighbor or community resource to act as their representative. Representatives and their contact information are entered in the Department's assessment. Representatives in conjunction with the participant make decisions involving:

- •Recruit staff
- •Select staff from worker registry
- •Hire staff common law employer
- •Specify additional staff qualifications based on participant needs and preferences
- •Determine staff duties based on needs identified in the Department's assessment
- •Notify the Department if the participant's needs are not being met
- •Orient and instruct staff in duties
- •Evaluate staff performance
- •Verify time worked by staff and approve time sheets
- •Discharge staff (common law employer)

At time of assessment a plan is developed identifying how direction will occur by the representative. Options for care planning may include arrangement for:

- •A reliable informal caregiver to identify when problems with care exist.
- •Authorization of more than one provider to provide care so that there is an "additional set of eyes" in the client's home which provides additional monitoring that representatives are functioning in the participant's best interests.
- •other services such as authorization of home delivered meals or adult day care
- •More frequent Case Manager contact with the client.
- •Periodic contact with other professionals.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Care	<u>~</u>	

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- **h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:
 - Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. Check each that applies:

▼ Governmental entities

Private	antitios
Private	entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:
 - FMS are covered as the waiver service specified in Appendix C1/C3

The waiver service entitled:

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

State Medicaid Agency

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Per the CMS approved cost allocation plan

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (check each that applies):

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status
- Collects and processes timesheets of support workers
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- **Other**

Specify:

The Medicaid Agency completes background checks and contracts with providers.

The process for collecting and processing timesheets can be either paper based or telephonic depending on the preference of the provider. The state produces a paper invoice with authorized hours. The provider must enter actual hours and sign the invoice. Accuracy is verified retrospectively via quality assurance processes.

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget
- Tracks and reports participant funds, disbursements and the balance of participant funds
- Processes and pays invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participantdirected budget
- ☐ Other services and supports

	Specify:
Add	itional functions/activities:
	Executes and holds Medicaid provider agreements as authorized under a written agreement
	with the Medicaid agency Receives and disburses funds for the payment of participant-directed services under an
	agreement with the Medicaid agency or operating agency Provides other entities specified by the State with periodic reports of expenditures and the
~	status of the participant-directed budget Other
	Specific

Specify:

The State Medicaid Agency provides FMS including executing and holding the Medicaid provider

- iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
 - (a) Monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform:

The state Medicaid agency performs the FMS functions.

Routine methods to assure accuracy of payments and client satisfaction are as follows: Supervisory review of client files; Case Resource Managers/Social Workers verify during annual reviews that services were provided as planned, the State Auditors Office and Operations Review and Consultation conduct routine audits of agency payments. The state Medicaid agency conducts client satisfaction surveys every two years. AAAs are required to conduct client satisfaction surveys every two years.

- (b) The entity (or entities) responsible for this monitoring: The State Auditors Office and Operation Review and Consultation conduct routine audits of agency payments.
- (c) How frequently performance is assessed: Performance is assessed by the Case Manager at least annually at the time of plan review and at significant change, the State Auditors Office performs annual audits of the state Medicaid agency, and Operations Review and Consultation (an internal DSHS office) performs periodic audits of state programs. The state Medicaid agency conducts client satisfaction surveys every two years. AAAs are required to conduct client satisfaction surveys every two years.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):
 - **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each

participant direction opportunity under the waiver:

Waiver Service Coverage. Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Nurse Delegation	П
Skilled Nursing	
Adult Day Care	
Caregiver/Recipient Training Services	
Home Health Aide	
Personal Care	
Community Transition Services	
Transportation	
Personal Emergency Response	
Home Delivered Meals	
Environmental Accessibility Adaptations	
Managed Care Option - Capitated	
Specialized Medical Equipment and Supplies	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

- (a) The types of entities that furnish these supports: The State Medicaid Agency, AAAs and the Home Care Quality Authority (HCQA)
- (b) How the supports are procured and compensated: Case management through the Medicaid Agency and AAAs is funded through state funds and administrative match per the approved cost allocation plan; HCQA is a state agency funded by administrative match per the cost allocation plan and through legislative appropriation of state general funds.
- (c) Describe in detail the supports that are furnished for each participant direction opportunity under the waiver: During service plan development the Case Manager is responsible for informing the waiver participant of their ability to choose an individual provider or an agency provider. If the waiver participant chooses an individual provider they are informed they will become the employer of record and are given a form booklet entitled

The "Medicaid and Long Term Care Services for Adults". This document provides the waiver participant with:

- Information about being an employer and resources for related skill development
- Information about the financial management role of DSHS
- Information about the role of the Home Care Quality Authority (HCQA)

The Home Care Quality Authority (HCQA) provides:

- A referral Registry used to connect waiver participants to providers and staff to assist.
- Assistance with hiring and employee management.

- · Client training on employer functions
- (d) The methods and frequency of assessing the performance of the entities that furnish these supports: State Case Managers receive yearly performance evaluations per state personnel policies. Supervisory audits are required for a standard percentage of records for each case manager.

AAAs are monitored on-site every two years and receive desk audits in the alternate year.

The ADSA Quality Assurance Unit conducts record reviews on an 18 month cycle state-wide.

The legislature conducts an audit of HCQA every three years.

e) The entity or entities responsible for assessing performance: The Department of Social and Health Services (State Medicaid Agency) and the legislature.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

- k. Independent Advocacy (select one).
 - No. Arrangements have not been made for independent advocacy.
 - Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E:	Participant	Direction	of Services	

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants are able to switch to and from agency/individual provided personal care at any time. The Case Manager facilitates the transition and assures continuity of care from one provider to the next.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The state does not have a mechanism for involuntary termination of participant direction. The state may terminate payment to an individual provider for cause. In this situation the Case Manager assures continuity of care.

The Challenging Client Protocol provides guidance to case managers assisting participants who have difficulty developing and following a plan that provides for the their health and welfare. This protocol guides the case

manager through steps to secure additional supports or explore alternate service options with participants such as transitioning to provider managed personal care.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Table D-1-H				
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority		
Waiver Year	Number of Participants	Number of Participants		
Year 1	11130			
Year 2	11148			
Year 3	11167			
Year 4 (renewal only)	11185			
Year 5 (renewal only)	11204			

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- **a.** Participant Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:
 - i. Participant Employer Status. Specify the participant's employer status under the waiver. Select one or both:
 - Participant/Co-Employer. The participant (or the participant's representative) functions as the coemployer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
- **ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:
 - **▼** Recruit staff

	Refer staff to agency for hiring (co-employer)
V	Select staff from worker registry
V	Hire staff common law employer
	Verify staff qualifications
	Obtain criminal history and/or background investigation of staff
	Specify how the costs of such investigations are compensated:
V	Specify additional staff qualifications based on participant needs and preferences so long as such
~	qualifications are consistent with the qualifications specified in Appendix C-1/C-3. Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
	Determine staff wages and benefits subject to State limits
V	Schedule staff
V	Orient and instruct staff in duties
V	Supervise staff
V	Evaluate staff performance
V	Verify time worked by staff and approve time sheets
V	Discharge staff (common law employer)
	Discharge staff from providing services (co-employer)
	Other
	Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i.	Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. <i>Select one or more</i> :
	Reallocate funds among services included in the budget
	☐ Determine the amount paid for services within the State's established limits
	☐ Substitute service providers
	☐ Schedule the provision of services
	Specify additional service provider qualifications consistent with the qualifications specified in
	Appendix C-1/C-3 Specify how services are provided, consistent with the service specifications contained in Appendix
	C-1/C-3
	☐ Identify service providers and refer for provider enrollment
	Authorize payment for waiver goods and services

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. Participant Exercise of Budget Flexibility. Select one:
 - Modifications to the participant directed budget must be preceded by a change in the service plan.
 - The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service

specify the entity that reviews the proposed change:	

plan. When prior review of changes is required in certain circumstances, describe the circumstances and

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Fair hearing policies and corresponding State regulations ensure that all persons have the right to apply for Long-term Care (LTC) services administered by the department, and all applicants/clients have the right to have their financial and program eligibility determined by the department, the right to appeal any decision made by AAA or HCS staff which they perceive as adversely impacting their LTC services including, but not limited to the denial of services, reduction in the level of services, suspension of services, or termination of service. Fair Hearing Policy and Procedure is outlined in Chapter 1 of the State Long Term Care Manual. Implementation and tracking of Fair Hearings is accomplished through an automated database.

All waiver clients sign and receive a copy the 'Acknowledgement of Services' form (DSHS 14-225). This form is used to inform clients of their choices regarding waiver and institutional services and of their fair hearing rights.

The case manager informs the applicant/client verbally AND in writing when the AAA or HCS denies, suspends, reduces, or terminates services and explains the reason(s) for the action or decision in question, including the facts upon which the decision was based. This notice includes language that is found in Washington Administrative Code that informs the client that they have a right to continuing benefits pending the outcome of the administrative hearing if they request a hearing by the effective date of the department's decision or the end of the month in which the effective date occurs.

The applicant/client must always be informed of the right to a fair hearing and how to make a fair hearing request. A fair hearing request form (DSHS 08-013) is included with the letter sent to the client. The client is informed that fair hearing requests may be made verbally or in writing. Planned Action Notices are currently retained in the client's record. Decisions are kept with the same retention as other client documents.

The case manager documents in the Service Episode Record (SER) the date, topic of discussion, that the fair hearing process has been explained; and the client's decision.

Medicaid Agency References:

DSHS form 14-225 - Acknowledgement of Services

Chapter 388-02 WAC

DSHS hearing rules

WAC 388-02 and its successors

GENERAL

388-02-0005 What is the purpose and scope of this chapter?

388-02-0010 What definitions apply to this chapter?

388-02-0015 How do the terms in the Administrative Procedure Act (APA) compare to this chapter?

388-02-0020 What does good cause mean?

ADDRESSES

388-02-0025 Where is the office of administrative hearings located?

388-02-0030 Where is the board of appeals located?

DEADLINES

388-02-0035 How are days counted when calculating deadlines for the hearing process?

FILING AND SERVING PAPERS

388-02-0040 How do parties send documents?

388-02-0045 What is service?

388-02-0050 How does a party serve someone?

388-02-0055 When must a party serve someone?

388-02-0060 When is service complete?

388-02-0065 How does a party prove service?

388-02-0070 What is filing?

388-02-0075 How does a party file documents?

RESOLUTION OF DISPUTES

388-02-0080 What are your options for resolving a dispute with DSHS?

HEARING RIGHTS AND REQUESTS

388-02-0085 Do you have a right to a hearing?

388-02-0090 Who may request a hearing?

388-02-0095 What if you have questions about requesting a hearing?

388-02-0100 How do you request a hearing?

388-02-0105 What information do you give when requesting a hearing?

388-02-0110 What happens after you request a hearing?

388-02-0115 May you withdraw your hearing request?

INTERPRETERS

388-02-0120 Do you have the right to an interpreter in the hearing process?

388-02-0125 What definitions apply to limited English proficient (LEP) parties?

388-02-0130 What requirements apply to notices for limited English speaking parties?

388-02-0135 What requirements apply to interpreters?

388-02-0140 May you waive interpreter services?

388-02-0145 What requirements apply to the use of interpreters?

388-02-0150 What requirements apply to hearing decisions involving limited English speaking parties?

REPRESENTATION DURING THE HEARING PROCESS

388-02-0155 Who represents you during the hearing process?

388-02-0160 If a DSHS employee cannot represent you, can they assist you during the hearing process?

388-02-0165 What if you would like to be represented by an attorney but you cannot afford one?

388-02-0170 Who represents DSHS during the hearing?

PREHEARING MEETING WITH A DSHS REPRESENTATIVE

388-02-0175 What is a prehearing meeting?

388-02-0180 What happens during a prehearing meeting?

388-02-0185 What happens after a prehearing meeting?

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388-02-0190 What happens if you do not participate in a prehearing meeting?
PREHEARING CONFERENCE WITH AN ADMINISTRATIVE LAW JUDGE
388-02-0195 What is a prehearing conference?
388-02-0200 What happens during a prehearing conference?
388-02-0205 What happens after a prehearing conference?
388-02-0210 What happens if a party does not attend a prehearing conference?
ADMINISTRATIVE LAW JUDGES
388-02-0215 What is the authority of the ALJ?
388-02-0220 What rules and laws must an ALJ and review judge apply when making a decision?
388-02-0225 May an ALJ or review judge decide that a DSHS rule is invalid?
388-02-0230 When is the ALJ assigned to the hearing?
388-02-0235 May a party request a different judge?
388-02-0240 How does a party file a motion of prejudice?
388-02-0245 May an ALJ or review judge be disqualified?
NOTICES
388-02-0250 What happens after you request a hearing?
388-02-0255 What information must OAH include in the notice of hearing?
388-02-0260 May DSHS amend a notice?
388-02-0265 May you amend your hearing request?
388-02-0270 Must you tell DSHS and OAH when your mailing address changes?
CONTINUANCES
388-02-0275 What is a continuance?
388-02-0280 Who may request a continuance?
DISMISSALS
388-02-0285 What is an order of dismissal?
388-02-0290 If your hearing is dismissed, may you request another hearing?
388-02-0295 Where do you send a request to vacate an order of dismissal?
388-02-0300 What is the deadline for vacating an order of dismissal?
388-02-0305 How does an ALJ vacate an order of dismissal?
STAYS
388-02-0310 May a party request a stay of DSHS action?
SUBPOENAS
388-02-0315 May a party require witnesses to testify or provide documents?
388-02-0320 Who may prepare a subpoena?
388-02-0325 How is a subpoena served?
388-02-0330 May the ALJ quash a subpoena?
388-02-0335 Do you have to pay for a subpoena?
HEARING METHODS
388-02-0340 How is your hearing held?
388-02-0345 Is an ALJ present at your hearing?
388-02-0350 Is your hearing recorded?
388-02-0355 Who may attend your hearing?
388-02-0360 May a party convert how a hearing is held?
388-02-0365 How does a party convert how a hearing is held or how the witnesses or parties appear?
388-02-0370 How are documents submitted for a telephone conference?
388-02-0375 What happens at your hearing?
388-02-0380 What is a group hearing?
388-02-0385 May a party withdraw from a group hearing?
EVIDENCE
388-02-0390 What is evidence?
388-02-0395 When may the parties bring in evidence?
388-02-0400 What evidence may the parties present during the hearing?
388-02-0405 What is a stipulation?
388-02-0410 After the parties agree to a stipulation, may they change or reject it?
388-02-0415 What are proposed exhibits?
388-02-0420 Do the parties mark and number their proposed exhibits?
388-02-0425 Who decides whether to admit proposed exhibits into the record?
388-02-0430 What may a party do if they disagree with an exhibit?
388-02-0435 When should an ALJ receive proposed exhibits for a telephone hearing?
388-02-0440 What is judicial notice?
388-02-0445 How does the ALJ respond to requests to take judicial notice?
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388-02-0450 What is a witness?
388-02-0455 Who may be a witness?
388-02-0460 How do witnesses testify?
388-02-0465 May the parties cross-examine a witness?
388-02-0470 May witnesses refuse to answer questions?
PROOF
388-02-0475 What evidence does an ALJ consider?
388-02-0480 What does burden of proof mean?
388-02-0485 What is the standard of proof?
388-02-0490 How is a position proven at hearing?
388-02-0495 What is equitable estoppel?
RECORD CLOSURE
388-02-0500 What may an ALJ do before the record is closed?
388-02-0505 When is the record closed?
388-02-0510 What happens when the record is closed?
HEARING DECISIONS
388-02-0515 What happens after the record is closed?
388-02-0520 What information must the ALJ include in the decision?
388-02-0524 In what cases does the ALJ enter the hearing decision as an initial order?
388-02-0525 When do initial orders become final?
388-02-0527 In what cases does the ALJ enter the hearing decision as a final order?
388-02-0530 What if a party disagrees with the ALJ's decision?
CLERICAL ERRORS IN ALJ DECISIONS
388-02-0540 How are clerical errors in ALJ decisions corrected?
388-02-0545 How does a party ask for a corrected ALJ decision?
388-02-0550 How much time do the parties have to ask for a corrected ALJ decision?
388-02-0555 What happens when a party requests a corrected ALJ decision?
REQUESTS FOR BOA REVIEW OF INITIAL ORDERS FOR CASES LISTED IN WAC 388-02-0215(4)
388-02-0560 What is review?
388-02-0565 What evidence does the review judge consider in a decision?
388-02-0570 Who may request review?
388-02-0575 What must a party include in the review request?
388-02-0580 What is the deadline for requesting review of cases listed in WAC 388-02-0215(4)?
388-02-0585 Where does a party send a request to review a case listed in WAC 388-02-0215(4)?
388-02-0590 How does a party respond to the review request?
388-02-0595 What happens after the response deadline?
REVIEW JUDGES
388-02-0600 What is the authority of the review judge?
REQUESTS FOR RECONSIDERATION OF FINAL ORDERS ENTERED BY OAH AND BOA
388-02-0605 What if a party does not agree with a final order entered by OAH or BOA?
388-02-0610 What is reconsideration?
388-02-0615 What must a party include in the reconsideration request?
388-02-0620 What is the deadline for requesting reconsideration?
388-02-0625 Where does a party send a reconsideration request?
388-02-0630 How does a party respond to a reconsideration request?
388-02-0635 What happens after a party requests reconsideration?
REQUESTS FOR JUDICIAL REVIEW OF FINAL ORDERS
388-02-0640 What is judicial review?
388-02-0645 When must you ask for judicial review?
388-02-0650 How do you serve your petition for judicial review?
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Long Term Care Manual Chapter 1

WITNESSES

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while

preserving their right to a Fair Hearing. Select one:

- No. This Appendix does not apply
- Yes. The State operates an additional dispute resolution process
- b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System. Select one:
 - No. This Appendix does not apply
 - Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver
- **b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The system is operated by the Medicaid Agency through the Aging and Disability Services Administration

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

References:(1) ADSA Complaint/Grievance Policy for Home and Community Services Division and the Division of Developmental Disabilities

- (2) Management Bulletin H05-018 Policy/Procedure Client Grievance Policy March 2005
- (3)DSHS Administrative Policy No. 8.11

Describe the grievance/complaint system, including:

(a) the types of grievances/complaints that participants may register;

Participants may register complaints about anything the Department does or is responsible for that they perceive as effecting them negetively in any way. To protect participant rights, some types of complaints are immediately directed to other formal systems rather than being addressed through the grievance process.

All participants receive the document, "Your Rights and Responsibilities When You Receive Services Offered by Aging and Disability Services Administration". This document informs participants that they have the right to make a complaint and also have the right to separately file a Fair Hearing. In addition, participants receive a Planned Action Notice informing them of all actions taken by ADSA. This notice outlines the Fair Hearing process and offers participants the pamphlet entitled "Your Hearing Rights in a DSHS Case". The pamphlet, "Your Hearing Rights in a DSHS Case", explains that an optional opportunity to settle the case before the hearing is available and also explains that if an agreement cannot be reached the right to a Fair Hearing remains.

Complaints not handled through the grievance process include the following:

- a. Complaints of abuse, neglect or financial exploitation of a vulnerable adult or child referred to formal protective systems
- b. Client disputes about services that have been Denied, Reduced, Suspended, or Terminated client is informed of their rights and referred to the fair hearing process
- c. Complaints about possible Medicaid fraud referred to the Medicaid Fraud Control Unit

(b) the process and timelines for addressing grievances/complaints;

Complaints can be received and addressed at any level of the organization. However, ADSA always strives to address grievances/complaints at the lowest level possible. Upon receipt at any level, all DSHS employees are required to respond to in-person or telephone complaints within 1 business day. Writen complaints must receive a response within 7 business days. Complaints are referred to the case manager for action unless the complainant requests it not be. If the casemanager is unable to resolve the complaint, the person is referred to the casemanager's supervisor. The supervisor has ten working days from the date of receipt to attempt to resolve the issue. If the person feels their complaint is not resolved they are referred to the Regional Manager/AAA Director. The Manager/Director has ten working days to seek resolution. If the person continues to feel their complaint is not resolved, they are referred to the state level ADSA headquarters. ADSA has ten working days to resolve the complaint and must notify the person in writing of the outcome. All steps in this process are logged.

As part of the pre-hearing process, the administrative hearing coordinator is responsible for clarifying the issues that the client is disputing. If the dispute is in relation to a personality conflict with the case manager, for instance, or a dispute that falls outside of WAC/eligibility, the coordinator informs the client about their grievance procedure. A case manager, supervisor, etc. may also inform the client about the agency's grievance procedure. If the issue is the denial of an Exception to Rule request, the Notice of Action, Exception to Rule that is given to the client contains the grievance procedure.

(c) the mechanisms that are used to resolve grievances/complaints.

Mechanisims that are used as appropriate to the type of complaint may include record review and correction of any errors; case conferences with the client; a change of providers; information and referral; additional information on program policies, statutes, administrative rules; and adjustment to the plan of care.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- **a.** Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. Select one:
 - Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)
 - No. This Appendix does not apply (do not complete Items b through e)

 If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.
- b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services by phone, fax, letter, or in-person.

References:

- -RCW 74.34: Abuse of Vulnerable Adults statute
- -WAC 388-71-0100 through 01280: Adult Protective Services
- -HCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

Required reporting of allegations involving waiver participants: What, when and to whom:

RCW 74.34.035 Reports (excerpt):

- (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.
- (2) When there is reason to suspect that sexual assault has occurred, mandated reporters shall immediately report to the appropriate law enforcement agency and to the department.
- (3) When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm:
- (a) Mandated reporters shall immediately report to the department; and
- (b) Mandated reporters shall immediately report to the appropriate law enforcement agency, except as provided in subsection (4) of this section.
- (4) A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:
- (a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;
- (b) There is a fracture;
- (c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or
- (d) There is an attempt to choke a vulnerable adult.

Types of Abuse under RCW 74.34.020

"Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care. "Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult which have the following meanings:

"Sexual abuse" means any form of nonconsensual sexual contact including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under Chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under Chapter 71A.12 RCW, whether or not it is consensual. "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to: striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

"Mental abuse" means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to: coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

"Exploitation" means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage.

"Neglect" means:

A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

"Self-neglect" means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

Required reporters of allegations of abuse, abandonment, neglect and financial exploitation:

RCW 74.34.020 Definitions: (8) "Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The following resources illustrate ways that participants, family members, caregivers and/or legal representatives are provided information about protections from mistreatment and told how to report concerns or incidents of abuse, neglect, and exploitation:

Participants receive information at least annualy during their annual assessment or more frequently if their situation changes significantly. Every CARE assessment addresses potential abuse, neglect and exploitation. This information is provided by the SW/CM verbally and in ADSA publication, Medicaid and Options for Long-Term Care Services for Adults which is provided during the assessment.

At the time of assessment each participant reviews and signs a form entitled "Your Rights and Responsibilities" (including the right to be free from abuse...) at the time they accept services.

The participant financial eligibility process also includes a review of funds and information on client financial rights.

Other resources available to participants and representatives include:

- •Provider training (e.g., Caregiver Orientation, and Revised Fundamentals of Caregiving and Safety Training);
- •ADSA and DSHS internet websites;
- •Eldercare Locator (AoA);
- •DSHS End Harm campaign and the activities associated with the annual statewide July Adult Abuse Prevention month.
- **d.** Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

References:

oRCW 74.34: Abuse of Vulnerable Adults statute oWAC 388-71-0100 through 01280: Adult Protective Services oHCS Long-Term Care Manual, Chapter 6, policies and procedures of the Adult Protective Services Program

Reports of the abuse, abandonment, neglect, financial exploitation or self-neglect of a participant are received by Adult Protective Services by phone, fax, letter, or in-person.

When indicated, APS will summon an appropriate emergency resource during intake (e.g., law enforcement when a crime against a person or property is in progress; emergency medical services when the vulnerable adult is in need of immediate medical assistance; or a mental health agency when the vulnerable adult is threatening to harm self or others or cognitive impairment is so severe that it is unsafe to be alone).

Each intake report is reviewed and preliminary information is gathered in order to determine if APS has jurisdiction; whether the allegations will be investigated by APS; and the time frame for initiation of each investigation.

Based on the facts and circumstances known at intake, reports are prioritized and assigned for investigation based on the severity and immediacy of actual or potential physical, mental or financial harm to the alleged victim, as follows:

•"High" priority when serious or life threatening harm is occurring or appears to be imminent.

- -APS will conduct an unannounced private interview with the alleged victim within 24 hours of receipt of the report.
- •"Medium" priority when harm that is more than minor, but does not appear to be life threatening at this time, has occurred, is on going, or may occur.
- -APS will conduct an unannounced private interview with the alleged victim within 5 working days of receipt of the report.
- •"Low" priority when harm that poses a minor risk at this time to health or safety, has occurred, is ongoing, or may occur
- -APS will conduct an unannounced private interview with the alleged victim within 10 working days of receipt of the report.

On a case-by-case basis, the supervisor or designee may specify a specific response time shorter than the maximum response time designated for the priority level.

The participant or the participant's representative is informed of the results of the investigation verbally and, if requested, will receive a redacted copy of the report. For unsubstantiated results the participant/representative receives verbal notification at the end of the investigation. For substantiated results, the participant receives verbal notification (written when requested) at two stages throughout the investigation; (1) when a determination by the investigator to recommend that the allegation be substantiated and (2) when this determination has been reviewed by the regional reviewing authority.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Adult Protective Services is a state wide program within the state single Medicaid agency. The intakes, investigations and protective services performed by APS are continuously monitored at both the state and the regional levels. For example:

oRegional supervisors and program managers conduct on-going quality assurance audits of APS case records.

oThe APS program has implemented a new statewide QA monitoring process that includes record reviews and a formal in-person skills evaluation conducted by a supervisor during an actual APS investigation.

oSeveral reports based on data pulled from the statewide APS data base are routinely generated and evaluated no less than annually by program managers and upper management at the state office.

oThe regions have and use a report system tool that enables them to create customized reports pulled from the statewide data base to track, monitor and evaluate implementation of APS in their region.

oAPS also routinely reports some aspects of program performance to the Governor for her review (Government Management Accountability and Performance).

oData is used to develop statewide training for case managers and the community on adult protective services and how to recognize and prevent instances or re-occurances of abuse, neglect and exploitation.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

- a. Use of Restraints or Seclusion. (Select one):
 - The State does not permit or prohibits the use of restraints or seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The Medicaid Agency through the Aging and Disability Services Administration is responsible for detecting the

unauthorized use of restraints or seclusion.

Required training for all paid caregivers includes clear instructions that any use of seclusion or restraint is prohibited. Caregivers are among the people that Washington State Law (RCW 74.34) lists as mandatory reporters of suspected abuse. Mandatory training includes detailed information on types of prohibited restraint (physical, chemical, environmental), risks related to the use of restraints, and alternatives to the use of restraints.

The Medicaid Agency detects use of restraint and seclusion through reports received in the Adult Protective Services system, through the face to face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints.

Clients who choose to self direct their personal care have the authority to hire and fire at any time providing an additional protection.

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.
 - i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
 - ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- **b.** Use of Restrictive Interventions. (Select one):
 - The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Medicaid Agency through the Aging and Disabiliy Services Administration is responsible for detecting the unauthorized use of restrictive interventions.

Required training for all paid caregivers includes clear instructions that any use of restrictive intervention is prohibited. Mandatory training includes detailed information on types restrictive interventions that are beyond the obvious use of restraint and seclusion. Training also includes multiple alternatives to restrictive intervention and instructs the caregiver to consult with others involved in the person's care such as family and case managers.

The Medicaid Agency detects use of restrictive intervention through reports received in the Adult Protective Services system, through the face to face CARE assessment process conducted yearly and at significant change, through the grievance process and through quality assurance activities that may include face to face interviews of clients and review of complaints.

Clients who choose to self direct their personal care have the authority to hire and fire at any time.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.
 - i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

11.	State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and
	overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability. Select one:
 - No. This Appendix is not applicable (do not complete the remaining items)
 - **Yes.** This Appendix applies (complete the remaining items)
- b. Medication Management and Follow-Up
 - **i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Boarding Home (BH) and Adult Family (AFH) Home staff have ongoing responsibility for monitoring participant medication regimes for those participants requiring assistance with or administration of medications. After completing a full assessment of the participant's treatments and medications, each setting is required to develop an individualized plan to provide medication assistance. This assistance is documented in the participant's Negotiated Service Plan

Medication assistance or administration is monitored each time the medication is taken or applied. Medication logs are used to document medication usage.

Licensing surveys of adult residential care facilities include monitoring to WAC which prohibits the use of medications as chemical restraint for discipline and convenience and requires that negotiated care plan includes strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed. WAC further requires that psychopharmacological drugs are prescribed by a physician or health care professional with prescriptive authority and that changes in medication only occur when the prescriber decides it is medically necessary. In addition to licensing surveys which are completed on average cycle of 15 months, the Residential Care Services Division investigates reported complaints and concerns involving medications.

Additional monitoring of medications is provided by case management staff responding to assessment triggers by initiating a nursing referral. The CARE assessment tool has built in triggers that alert the case manager to the presence of a medication regime that has an effect on client assessment, service planning and delivery. Nursing referrals may be triggered by:

- a. A Medication level that is "must be administered to person" and:
- -The client is choking or gagging on medications; or

- -The client is not taking medications as ordered; or
- b. The client is declining assistance with medications and:
- -not taking medications as ordered; and
- -Has greater than one ER visit or greater than one hospitalization in the last six months; or
- c. The client's medication regimen is complex and:
- -The client has multiple prescribers; and
- -The client has had greater than one ER visit or greater than one hospitalization in the last six months; and
- -The client is not taking medications as ordered.
- ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The CARE Assessment triggers a referral to Nursing Services when certain indicators are identified in the area of medication management. When a referral is indicated the case manager discusses the situation with the participant and documents the discussion in CARE. If the client agrees to a referral, documentation includes; the date of referral and who is responsible to follow through. A referral is not necessary if the client states they will discuss the issue with their healthcare provider at the next visit.

Referrals are triggered by:

- a. A Medication level that is "must be administered to person" and:
- -The client is choking or gagging on medications; or
- -The client is not taking medications as ordered; or
- b. The client is declining assistance with medications and:
- -not taking medications as ordered; and
- -Has greater than one ER visit or greater than one hospitalization in the last six months; or
- c. The client's medication regimen is complex and:
- -The client has multiple prescribers; and
- -The client has had greater than one ER visit or greater than one hospitalization in the last six months; and
- -The client is not taking medications as ordered.

Residential Care Services (RCS), a division of the State Medicaid agency, conducts regular oversight inspections of all AFH and BH as part of the re-licensing process. These visits occur on 15-18 month cycles. Inspectors monitor that medication assistance or administration is outlined in the participant's Negotiated Care Plan and implemented accordingly. In addition to licensing inspection visits, inspections are also prompted by reports and complaints made to the RCS complaint hot-line. RCS collects trend, patterns and significant issues identified through licensing inspections and/or calls to the complaint line. Provider letters are sent to all AFH and BH proprietors addressing these concerns.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

- c. Medication Administration by Waiver Providers
 - i. Provider Administration of Medications. Select one:
 - Not applicable. (do not complete the remaining items)
 - Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (complete the remaining items)
 - ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

WAC 246-888 provides guidance to residents and providers in community based care settings on medication assistance and administration: Self-administration with assistance means assistance with legend drugs and controlled substances rendered by a non-practitioner to an individual residing in a community-based care setting or an in-home care setting. It includes reminding or coaching the individual to take their medication, handing the medication container to the individual, opening the medication container, using an enabler, or placing the medication in the hand of the individual/resident. The individual/resident must be able to put the medication into his or her mouth or apply or instill the medication. The individual/resident does not necessarily need to state the name of the medication, intended effects, side effects, or other details, but must be aware that he/she is receiving medications. Assistance may be provided with prefilled insulin syringes. Assistance is limited to handing the prefilled insulin syringe to an individual/resident. Assistance with the administration of any other intravenous and/or injectable medication is specifically excluded. The individual/resident retains the right to refuse medication. Self-administration with assistance shall occur immediately prior to the ingestion or application of a medication.

Independent self-administration occurs when an individual/resident is independently able to directly apply a legend drug or controlled substance by ingestion, inhalation, injection or other means. In licensed boarding homes, self-administration may include situations in which an individual cannot physically self-administer medications but can accurately direct others.

If an individual/resident is not able to physically ingest or apply a medication independently or with assistance, then the medication must be administered to the individual/resident by a person legally authorized to do so (e.g., physician, nurse, pharmacist). All laws and regulations applicable to medication administration apply. If an individual/resident cannot safely self-administer medication or self-administer with assistance and/or cannot indicate an awareness that he or she is taking a medication, then the medication must be administered to the individual/resident by a person legally authorized to do so.

WAC 246-840-910 describes the conditions under which a licensed registered nurse may delegate specific nursing care tasks to nursing assistants who meet certain requirements and provide care to individuals in a community-based care setting: A licensed registered nurse may delegate specific nursing care tasks to nursing assistants who meet certain requirements and provide care to individuals in a community-based care setting.

Before delegating a nursing task, the registered nurse delegator must determine that it is appropriate to delegate based on the following criteria:

- (2) Determine that the setting allows delegation because it is a community-based care setting or an inhome care setting.
- (3) Assess the patient's nursing care needs and determine that the patient is in a stable and predictable condition.
 - (4) Determine that the task to be delegated is within the delegating nurse's area of responsibility.
- (5) Determine that the task to be delegated can be properly and safely performed by the nursing assistant. The registered nurse delegator shall assess the potential risk of harm for the individual patient. Potential harm may include, but is not limited to, infection, hemorrhage, hypoxemia, nerve damage, physical injury, or psychological distress.
- (6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant to competently accomplish the task. The registered nurse delegator shall consider the psychomotor and cognitive skills required to perform the nursing task. More complex tasks may require additional training and supervision for the nursing assistant. The registered nurse delegator must identify and facilitate any additional training of the nursing assistant that is needed prior to delegation. The registered nurse delegator must ensure that the task to be delegated can be properly and safely performed by the nursing assistant.
- (7) Assess the level of interaction required, considering language or cultural diversity that may affect communication or the ability to accomplish the task to be delegated, as well as methods to facilitate the interaction.
 - (8) Verify that the nursing assistant:

- (a) Is currently registered or certified as a nursing assistant in Washington state and is in good standing without restriction;
- (b) As required in WAC 246-841-405 (2)(a), nursing assistants registered must complete both the basic caregiver training and core delegation training before performing any delegated task;
- (c) Has a certificate of completion issued by the department of social and health services indicating completion of the required core nurse delegation training; and
- (d) Is willing to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.
- (9) Assess the ability of the nursing assistant to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision to ensure that the nursing task can be properly and safely performed by the nursing assistant.
 - (10) If the registered nurse delegator determines delegation is appropriate, the nurse must:
- (a) Discuss the delegation process with the patient or authorized representative, including the level of training of the nursing assistant delivering care.
- (b) Obtain patient consent. The patient, or authorized representative, must give written, informed consent to the delegation process under chapter 7.70 RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within thirty days; electronic consent is an acceptable format.
- (c) Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse or nursing assistant will be participating in the process.
 - (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.
- (12) Provide specific, written delegation instructions to the nursing assistant with a copy maintained in the patient's record that include:
 - (a) The rationale for delegating the nursing task;
 - (b) That the delegated nursing task is specific to one patient and is not transferable to another patient;
- (c) That the delegated nursing task is specific to one nursing assistant and is not transferable to another nursing assistant;
 - (d) The nature of the condition requiring treatment and purpose of the delegated nursing task;
 - (e) A clear description of the procedure or steps to follow to perform the task;
 - (f) The predictable outcomes of the nursing task and how to effectively deal with them;
 - (g) The risks of the treatment;
 - (h) The interactions of prescribed medications;
- (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;
- (j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:
 - (i) How to notify the registered nurse delegator of the change;

- (ii) The process the registered nurse delegator will use to obtain verification from the health care provider of the change in the medical order; and
- (iii) The process to notify the nursing assistant of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;
 - (k) How to document the task in the patient's record;
- (l) Document what teaching was done and that a return demonstration, or other method for verification of competency, was correctly done; and
- (m) A plan of nursing supervision describing how frequently the registered nurse will supervise the performance of the delegated task by the nursing assistant and reevaluate the delegated nursing task. Supervision shall occur at least every ninety days.
- (13) The administration of medications may be delegated at the discretion of the registered nurse delegator but never by injection (by intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise). The registered nurse delegator must provide written parameters specific to an individual patient which includes guidelines for the nursing assistant to follow in the decision-making process to administer a medication and the procedure to follow for such administration.
- (14) Delegation requires the registered nurse delegator teach the nursing assistant how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.
- (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator must monitor the performance of the task(s) to assure compliance to established standards of practice, policies and procedures and to ensure appropriate documentation of the task(s).
- (16) The registered nurse delegator must evaluate the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.
- (17) The registered nurse delegator must supervise and evaluate the performance of the nursing assistant, including direct observation or other method of verification of competency of the nursing assistant to perform the delegated nursing task. The registered nurse delegator must also reevaluate the patient's condition, the care provided to the patient, the capability of the nursing assistant, the outcome of the task, and any problems.
- (18) The registered nurse delegator must ensure safe and effective services are provided. Reevaluation and documentation must occur at least every ninety days. Frequency of supervision is at the discretion of the registered nurse delegator.
- iii. Medication Error Reporting. Select one of the following:
 - © Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).

 Complete the following three items:
 - (a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported to Residential Complaint Unit

(b) Specify the types of medication errors that providers are required to *record*:

All medication errors are to be recorded.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors which may be the result of neglect are reported.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Residential Care Services (RCS), a division of the date Medicaid agency, conducts regular oversight inspections of all AFH and BH as part of the re-licensing process. These visits occur on 15-18 month cycles. Inspectors monitor that medication assistance or administration is outlined in the participant's Negotiated Care Plan and implemented accordingly. In addition to licensing inspection visits, inspections are also prompted to reports and complaints made to the RCS complaint hot-line. RCS collects trend, patterns and significant issues identified through licensing inspections and/or calls to the complaint line. Provider letters are sent to all AFH and BH proprietors addressing these concerns.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percent of APS investigations completed within mandatory timeframe: Numerator: Number of completed APS investigations completed within mandatory timeframes Denominator: Number of APS complaints investigatons

Data Source (Select one):

Other

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	№ 100% Review
☐ Operating Agency	 Monthly	Less than 100% Review

Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Specify: 6 months statewide analysis

Performance Measure:

Timely completion of Complaint Resolution Unit investigations: Numerator: Number of investigations completed within mandatory timeframes for individuals residing in residential care settings. Denominator: Number of complaints for individuals residing in residential care settings and assigned for investigation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	№ 100% Review
☐ Operating Agency	 Monthly	☐ Less than 100%

		Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:		
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	
V State Medicaid Agency	☐ Weekly	
☐ Operating Agency	✓ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	☐ Annually	
	Continuously and Ongoing	
	Specify: 6 month statewide analysis	

Number and percent of critical incidents requiring investigation, by type Numerator: Number of critical incidents requiring investigation by type Denominator: Number of critical incidents reported by type

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data		
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid	™ Weekly	№ 100% Review
Agency		
Operating Agency	■ Monthly	Less than 100%

		Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
		Other Specify:
	Other Specify:	

Data Aggregation and Analysis:		
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):	
V State Medicaid Agency	☐ Weekly	
☐ Operating Agency	✓ Monthly	
☐ Sub-State Entity	☐ Quarterly	
Other Specify:	☐ Annually	
	Continuously and Ongoing	
	Specify: 6 month statewide analysis	

Percent and number of critical incidents substantiated by type Numerator: Number of critical incidents substantiated, by type Denominator: Number of critical incidents investigated, by type

Data Source (Select one):

Other

If 'Other' is selected, specify:

Administrative Data			
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):	
▼ State Medicaid	 Weekly	№ 100% Review	
Agency			
Operating Agency	™ Monthly	Less than 100%	

		Review
□ Sub-State Entity	□ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
V State Medicaid Agency	☐ Weekly
☐ Operating Agency	✓ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Specify: 6 month statewide analysis

Percent of critical incidents that should have been reported Numerator: Number of records reviewed where a referral for APS/CRU/CPS was required and not completed **Denominator: Number of records reviewed**

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	™ Weekly	☐ 100% Review
Operating Agency	 ■ Monthly	Less than 100% Review

Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 18 Months	

Data Aggregation and Analysis:

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	 ☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

Performance Measure:

Percent of records reviewed where nursing referral is triggered and referral is made N: Number of records reviewed where nursing referral is triggered and made (or appropriate justification for not referring is identified) D: Number of records reviewed where nursing referral is triggered

Data Source (Select one): **Record reviews, off-site** If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	□ Weekly	☐ 100% Review
☐ Operating Agency	 ■ Monthly	Less than 100% Review

Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 18 months	

Data Aggregation and Analysis:

Data Aggregation and Analysis:	
Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify: 18 months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

ADSA has strong systems in place to address this assurance and to protect vulnerable adults in home and community settings from critical incidents and other life-endangering situations. The Quality Management Strategy for ensuring compliance with the Health and Welfare Assurance includes prevention training; community education and participation; continuous access to reporting, data collection, analysis, and policy review; monitoring provider actions taken when substantiation of abuse, neglect, abandonment or exploitation are found; monitoring, evaluation and actions taken by ADSA when required; investigation by law enforcement, adult protective services, residential care services and children's protective services for allegations of abuse, neglect, abandonment or exploitation.

Adult protective service supervisors monitor four investigation records per experienced investigator per year and complete one observation of an interview. For new staff, supervisors monitor the first ten investigations assigned, then five others throughout the year along with two interview observations within the first year of hire. Corrections are expected if appropriate and are verified by the supervisor. ADSA program managers at headquarters will begin monitoring a statistically valid sample of cases that have been screened out or closed with no APS investigation in 2009.

Adult protective services reports can be accessed in a variety of ways. Standard reports created by the Forecasting and Data Analysis unit are made available to all of ADSA. Ad hoc management reports, available from the ADSA website, can be customized and created upon demand through the APS automated system. These reports are available on a three level hierarchy of access: an individual APS worker may access reports about his/her own cases; APS supervisor/manager access reports about his/her own region, units, and workers; ADSA headquarters access reports about all individual workers, units, regions, and statewide. These reports are used for on-going evaluation to ensure that appropriate actions are taken in addition to the analysis of abuse, neglect and exploitation trends, and to facilitate day-to-day workload management.

The case manager documents and addresses health/safety interventions for waiver participants such as: PERS (Personal Emergency Response system), evacuation in an emergency, minimum case management contacts, case management, environmental modifications, client training, skin observation protocol, nursing referral indicators from triggered referral screen, assistance obtaining durable medical equipment, cognitive deficits, person(s) responsible for supervising caregivers, screen to document client falls, drug/alcohol assessments, depression screening, caregiver burnout, suicide risk, and other high risk indicators.

HCS/AAA Nursing services RNs respond to referrals by HCS/AAA case managers based on nursing indicators identified in CARE. Nurses document nursing services activities in CARE and collaborate with case managers on follow up recommendations.

RCS performs multiple levels of ongoing quality assurance related to complaint investigations for licensed residential providers. Investigative protocols have been developed for each licensed setting, and the protocols function as a tool to ensure that RCS staff are consistently and thoroughly investigating allegations of abuse and neglect in nursing homes, boarding homes, and adult family homes. All RCS staff and managers have been trained on the use of the protocols. The protocols and other informational resources that have been developed are intended to prospectively influence the quality of on-site investigative work.

RCS has also launched a formal semi-annual quality assurance review process in which a sample of completed investigations are reviewed retrospectively. Multiple objective criteria are used to determine if all elements of a thorough investigation are demonstrated through a random sample of completed investigations. Managers conduct this formal review process for work done in another field unit, so that objectivity is maintained. The process also includes a panel of headquarters reviewers who review the same sample of investigations, and then comparisons are made between findings. The protocols, operational principles and procedures, and the results of regional QA work are posted on a unique RCS web-site titled "Q-sure". This web-site is accessible to all RCS staff.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Adult protective services and complaint resolution reports are reviewed by individuals at each level (investigator, supervisor/manger, program manager, executive management) who decide on individual and systemic levels what, if any, corrections and improvements are needed. Reports to other licensing/certification agencies are made if needed, in some circumstances citations are written and followed up on by Residential Care Services. Based on data analysis and monitoring, training and/or mentoring is provided by local and regional offices. "Dear Provider" letters are issued by ADSA policy as guidance to residential providers based on trend areas such as: use of restraints or medication errors, problems with participant's funds, or certain types of abuse, neglect, or exploitation incidents.

Remediation for nursing services includes making individual corrections if appropriate when it is determined that a referral to nursing services should have been made or follow up was not completed within time frames.

Each HCS/AAA record is reviewed during the supervisory and quality assurance review cycle to determine if a mandatory referral to adult protective services or the residential complaint resolution unit should have been made. If appropriate, the HCS/AAA case manager is expected to make necessary corrections. Corrections are verified by either the QA unit or the case management supervisor. Reports and aggregate data are reviewed at all levels by individuals that make decisions on what improvements are needed individually or systemically. Regions and AAAs are required to develop corrective action plans to address any area where proficiency was less than 100%. Draft plans are reviewed by ADSA prior to approval and

implementation. Progress reports are produced every six months. Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

Remediation Data Aggregation

Remediation-related Data Aggregation	and Analysis (including trend identification
Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	™ Weekly
☐ Operating Agency	™ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	Annually
	Continuously and Ongoing
	Other Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

0	No
0	Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

This Quality Management Strategy encompasses the following Medicaid programs and waivers: State Plan Medicaid Personal Care, Community Options Program Entry System waiver (COPES - #0049), New Freedom waiver (#0443), Medically Needy Residential waiver (MNRW - #0390) and the Medically Needy In-Home waiver (MNIW - #0419)

Ongoing discovery and remediation is facilitated by regular reporting and communications among ADSA QA unit, Home & Community Programs, State Unit on Aging, State regional offices, Area Agencies on Aging, and other stakeholders including service providers and agencies. ADSA is the entity responsible for trending, prioritizing and determining system improvements based on the data analysis and remediation information from the ongoing quality improvement strategies. These processes are supported by the integral role of other waiver partners in providing data, which may also include data analysis, trending and the formulation of recommendations for system improvements. These partners include Residential Care Services, Home Care Quality Authority, Waiver Service Providers, Adult Protective Services, Social Service Payment System, Health and Recovery Services Administration, Mental Health Division, Division of Developmental Disability, Department of Health, and participants.

ADSA analyzes and trends data received from QA/QI activities and waiver partners. When data analysis identifies areas needing improvement, ADSA along with waiver partners, develop remediation strategies. Strategies are prioritized and change is implemented based on ADSAs strategic goals and available

resources.

Plans developed as a result of this process are shared with stakeholders for review and recommendations. Regular reporting and communication among waiver partners facilitate ongoing discovery and remediation.

ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
State Medicaid Agency	™ Weekly
Operating Agency	™ Monthly
Sub-State Entity	☐ Quarterly
Quality Improvement Committee	Annually
Other Specify: AAA	Other Specify: Every 18 months

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The QA monitoring application is an integral part of the discovery process and integrates the CMS quality framework and QA assurances. Data/reports produced from the QA application and CARE is key components of the overall Quality Management Strategy and is used for quality assurance/quality improvement activities or remediation.

Supervisory Reviews: HCS/AAA supervisors use the monitoring application to review and collect data on four records per experienced worker per year (estimated at 2500 records statewide/year based on 2007 workforce).

Training of new staff includes supervisory reviews using local monitoring tools to complete a 50% review of records during the first 6 months. The number of reviews completed varies depending on staff turnover. Data for new staff is not collected in the formal monitoring application.

The State Medicaid quality assurance unit reviews local monitoring activities during the HCS/AAA monitoring cycle. For experienced staff, reports are produced for analysis and action. Monitoring records are reviewed to ensure new staff monitoring is occurring.

Roles and Responsibilities:

The ADSA Quality Assurance Unit determines consumer satisfaction, program eligibility, accuracy and quality of file documents, and if policy & procedures, state and federal statutes including waiver requirements are met. The QA unit is responsible for monitoring six state regional areas and 13 Areas on Aging each review cycle (every 18 months). Entrance and exit conferences are held as well as technical assistance throughout the process. Detailed reports are produced and discussed with regions/AAAs. Follow up is done to verify that corrections have been made to critical areas (health & safety, eligibility, payment). Remediation plans are reviewed to ensure all required issues have been addressed and along with the HCS deputy director or State Unit on Aging office chief approves the remediation plans. In addition to monitoring social service and provider records, the QA unit conducts a Quality Improvement activity each review cycle (i.e.: inter rater reliability reviews, nursing facility discharge assessment, participant surveys, etc.), provides professional training/consultation to field staff, drafts amendments and revisions to the QA program including recommendations for policies and procedures. These recommendations are based upon quality assurance activity findings, feedback and input received from consumers and staff.

QA Unit Monitoring Process:

Review of a statistically valid sample: The State Medicaid quality assurance unit uses a statistically valid sample with a confidence level of 5%. A random sample is pulled and monitored over a statewide18 month review cycle.

During the 18 month review cycle each of the 19 offices is monitored based on an established schedule. Because of the time needed to complete a local review, overlap occurs. While one area is working on remediation and development of a corrective action plan, the monitoring begins in another location (i.e.: pulling a random sample and completing initial reviews). This ensures all areas are completed within the 18 month timeframe.

The QA unit uses a standardized monitoring process which includes:

- Pulling a random statistically valid sample and completing an initial review
- Meeting with the local management team, QA Program Manager, AAA lead and AAA liaison, and the HCS Deputy Director to review preliminary reports and discuss next action steps,
- Verifying remediation which is required at the individual level for areas identified
- Providing final reports for analysis and action
- o At the completion of each office's monitoring, data is analyzed and used to develop local corrective action plans, policy /procedural changes and training or guidance at the regional/AAA, unit, and/or worker level. o Ongoing analysis of data is reviewed. If a trend becomes evident after reviewing several offices, action is taken at the headquarters level without waiting for the completion of the review cycle (18 months).
- Reviewing and approval of each local regional/AAA corrective action plan.

Upon completion of the 18 month review cycle, statewide systemic data is analyzed for trends and patterns by managers, the ADSA Clinical Effectiveness and Performance Improvement Unit (CEPI) and executive staff. The CEPI unit conducts research into methods of improvement and training which are also incorporated into quality improvement activities. Decisions for action are made based on analysis and prioritization. These activities may include statewide training initiatives, policy and/or procedural changes and identification of quality improvement activities/projects.

Analysis of the previous review cycle plays a major role in determining the direction of the next18 month review cycle monitoring as well as quality improvement activities. Previous activities have included interrater reliability assessments, conducting a Personal Experience Survey, and nursing facility relocation reviews. Crosswalks are used to determine if improvements to the previous cycle's deficiencies have been made and if further action is required.

State Unit on Aging (SUA) is responsible for oversight of Area Agency on Aging (AAA) operations including implementation and compliance with contract requirements, state and federal laws and regulations, policies and procedures; approval and oversight of program budgets, billing for services provided, and Area Plan development and implementation; review of remediation (corrective action) plans submitted by AAAs to correct deficiencies in AAA operations and monitoring implementation of corrective actions; and review of monitoring reports submitted by AAAs for subcontractors to determine compliance with inter-local agreement and related laws and regulations.

Home and Community Programs (HCP) is responsible for development of policy and procedures related to HCS quality assurance/improvement activities, oversight of assessment, service planning and delivery models, monitoring compliance to Home and Community Programs (HCP), including HCBS. HCP monitors for irregularities in waiver or other payment authorizations through on-going review of Social Service Payment System (SSPS) reports. CARE generated reports are reviewed for program compliance and eligibility criteria; investigation of complaints or inquiries from the field staff, Medicaid fraud Control Unit, Payment Integrity unit, ADSA budget unit, constituents, legislative staff and other DSHS entities; review of various reports regarding the daily operation of the Home & Community programs; program review and eligibility consultation to supervisors and field staff; policy briefings and program updates for QA staff; social worker and case manager training; considers requests for additional personal care hours to meet exceptional need.

Program Managers within the State Unit on Aging and Home and Community Programs are responsible for analyzing various QA unit and CARE regional and statewide reports related to their programs to identify needed policy changes/clarifications, areas of improvement, and training.

Office chiefs for the State Unit on Aging and Home and Community programs are responsible for analyzing

the results of regional and statewide reports related to programs administered by Home and Community Services to identify and prioritize policy changes/clarifications, performance improvement activities, and training.

Clinical Effective and Performance Improvement (CEPI) Unit measures the effectiveness of assessment, care planning and interventions and recommends performance improvements. CEPI focuses on clinically effective performance measures and uses these measures to inform, design and develop methods to fully involve and empower recipients in managing their health outcomes, long-term care services and chronic illness; clinical competencies and training; clinical outcomes; long term care practice policy; and program delivery systems.

Adult Protective Services (APS) is responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who does not live in either a licensed setting or is served by a certified residential service. Local and statewide reports are available and reviewed by APS headquarters managers and field managers.

Residential Care Services (RCS) is responsible for investigating and making official findings on any accusations of abuse, neglect or exploitation of a vulnerable adult, who receives services from either a licensed setting or is served by a certified residential agency. RCS inspects and licenses adult family homes and boarding homes (assisted living and enhanced adult residential care facilities). Reports are available and reviewed by RCS and HCS.

Area Agencies on Aging (AAA) are responsible for discovery and remediation activities related to waiver provider contracts. AAAs monitor their four year Area Plan annually and create an area plan update to address issues identified.

Home and Community Services and Area Agency on Aging Supervisors are responsible for monitoring at a minimum, four records per worker per year (approximately 2500 statewide annually) to ensure accuracy and that a LOC and service plans are determined annually or at significant change. For new staff, a minimum of 50% of LOCs are reviewed during the first six months of employment. The number of reviews completed varies depending on staff turnover. Data for new staff is not collected in the formal monitoring application. Errors in assessment that can lead to an inaccurate eligibility determination, health and safety or payment issues are corrected immediately.

At a statewide level, the effectiveness of the waiver design is an ongoing process performed by the waiver manager and other staff responsible for the administration of the waiver. Data related to waiver functions is available from a variety of resources. Numerous reports and aggregate data generated by the QA application are available on a continuous basis for use by managers, supervisors and the QA Unit. ADSA QA policy and procedure, (Chapter 23 of the ADSA Long Term Care Manual), mandates that reports be used for discovery, remediation and to identify strengths and areas of improvement, training needs, areas of deficiencies and identify corrective action plans. There is continuity and integration of report review throughout ADSA.

At a local level, effectiveness of system change is also evaluated continuously and measured at each QA unit review cycle. Comparison monitoring reports measure whether a region/AAA declined, stayed the same, or improved from the previous review cycle.

The State Medicaid quality assurance unit reviews local monitoring activities during the HCS/AAA monitoring cycle. For experienced staff, reports are produced for analysis and action. Monitoring records are reviewed to ensure new staff monitoring is occurring.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is evaluated and adjusted prior to the beginning of a review cycle and each waiver renewal. In addition, it is also evaluated to determine if changes are needed Workgroups consisting of ADSA HQ program managers, Home and Community Services and Area Agency on Aging Supervisors, case managers, and nurses evaluate the QA strategy/program. Modifications/expectations are made based on changes in federal or state rules and regulations, ADSA policy and procedures, CMS assurances, input from participants, providers, and data from various reports including recommendations from the previous review cycle.

Appendix I: Financial Accountability

1-1. Pinanciai integrity and recountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) requirements concerning the independent audit of provider agencies;

Home Care Agencies are required to have an independent financial audit without findings covering the two year period prior to contracting. The audit must be conducted by a licensed CPA or a recognized financial firm. Federal rules are followed for agencies that have non-profit status per the Single Audit Act and OMB CIRCULAR A-133. A single or program specific audit is required for the AAA and other subcontractors who expend more than \$300,000 in federal assistance in a year.

If the subcontractor is a for-profit organization, it may be a subrecipient, but it will not fall under the OMB CIRCULAR A-133 requirements for a federal single or program-specific audit. In this unique case, the for-profit is monitored annually as follows:

- 1. By performing a desk review of the vendor's annual audit,
- 2. By on-site monitoring and completion of the monitoring worksheet. AAAs are required to use the following risk factors to help determine if on-site monitoring should be done.
- a. frequency of outside audits,
- b. prior audit findings,
- c. type of Contract,
- d. dollar amount of contract,
- e. internal control structure of subcontractor,
- f. abnormal frequency of personnel turnover,
- g. length of time as a subcontractor,
- h. history of marginal performance,
- i. has not conformed to conditions of previous contracts.
- 3. Review of subcontractor's relevant cost information when contract is renewed.

The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

(b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

AAAs are responsible for monitoring Home Care Agency service contractors with whom they have executed contracts. Full on-site monitoring occurs every two years. A new subcontractor must receive a full monitoring for each of the first two years they are under contract. Abbreviated monitoring occurs in each year when full on-site monitoring does not occur. Desk monitoring occurs semi-annually. Review tools and policies are available through ADSA. In addition to administrative review, client record and plan of care review, full on-site monitoring includes a fiscal review:

-Fiscal Review: Comparison of a sample of contractor billings/SSPS reports to contractor maintained documentation of work performed. A review of individual employee time records is part of this responsibility. The minimum sample size is 5% of current authorizations. The monitoring activity verifies that work billed for was performed, that the contractor is maintaining documentation of work performed and, that employees are paid for work performed. An abbreviated review consists of a review of complaints and review of any items where compliance was not met during the full review. The abbreviated monitoring must be expanded to full when a subcontractor exhibits significant problems that are not corrected as required by corrective action.

Desk monitoring consists of a review of program and financial reports to compare level of service provided to the level of service authorized. AAA verification of a sample of time keeping records is required for home care agencies that exceed a ratio of provided versus authorized hours of 92% or above for the quarter reviewed. AAAs must require a written response from home care agencies that have a quarterly ratio of provided versus authorized hours that are equal to or less than 75%. If the reason for the underserved hours is primarily due to an agency's inability to appropriately respond to referrals or provide adequate staffing levels, a corrective action must be submitted by the agency.

DSHS Payment Review Program:

DSHS launched the Payment Review Program in 1999 to employ new technology to assist with the regular DSHS review of Medicaid billings for accuracy. The focus of the Payment Review Program is to identify and prevent billing and payment errors. Originally, PRP only looked at claims through the MMIS. Social Service Payment System (SSPS) billings were added to PRP in 2002.

PRP employs algorithms to detect patterns and occurrences that may indicate problem billings. DSHS has an extensive internal algorithm development and review process. To keep providers informed about finalized algorithms, the Payment Review Program has posted the algorithm descriptions on the DSHS Internet site.

Teams of DSHS clinical, program and policy experts rigorously review all data analysis results from PRP reports to ensure accuracy.

Adult Day Care providers are reviewed at least annually per WAC 388-71-0724. Review includes administrative procedures and a required audited financial statement.

Monitoring for other waiver service contractors is conducted at a minimum every two years. AAAs may conduct either a full or abbreviated monitoring based on a usage/risk threshold. Triggers for a full monitoring are within a two year period: five or more authorizations or, one complaint concerning quality of care or client safety or, \$5000 or more in payments or any other reason the AAA thinks a contractor needs to be monitored.

Full monitoring of other waiver service contractors includes a comparison of contractor billings to contractor-maintained documentation of work performed. Verification that the work was performed should also be obtained from the client if possible. The minimum sample size for short term or one time services such as environmental modifications, specialized medical equipment is 5% of the total clients the contractor served in the previous two years. The minimum sample size for services that are generally ongoing such as skilled nursing or PERS is 5% of current authorizations. Monitoring includes review of individual files where they exist for services such as skilled nursing, client training, adult day care, home delivered meals and home health aide services.

(c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Medicaid Agency is responsible for conducting the financial review program of AAAs. AAAs are responsible for conducting financial review activities of subcontracted providers. The State Auditor's Office conducts the periodic independent audit of the waiver program as required by the single audit act.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Data Source (Select one):

Other

Percentage of clients for whom inappropriate payments were made after death. N= Number of deceased clients for whom inappropriate payments were made D= Number of deceased clients

Administrative data		
Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	™ Weekly	☑ 100% Review
☐ Operating Agency	 ■ Monthly	Less than 100% Review
Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval =
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	☐ Monthly
Sub-State Entity	☑ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify:

Percentage of service recipient records reviewed (from a representative sample) where service authorizations are supported by the amount, duration and frequency specified in the service plan. Note: record reviews comparing authorization data against the service plan are a proxy for comparing claims against the service plan. See i.a.ii below for further explanation.

Data Source (Select one): Record reviews, off-site If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
State Medicaid Agency	☐ Weekly	□ 100% Review
Operating Agency	 ■ Monthly	Less than 100% Review
□ Sub-State Entity	☐ Quarterly	Representative Sample Confidence Interval = 5%
Other Specify:	☐ Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 18 Months	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 Months

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

I.a.ii.

Performance Measure, #2 - The Medicaid Agency's review of authorizations (against service plans) is a proxy for claims review. Payment authorizations are manually generated by the case manager upon completion of the approved service plan, and then entered into the electronic Social Service Payment System (SSPS). SSPS generates an authorization number that is mailed to the provider. The Medicaid Agency's payment system prevents fraudulent claims from being paid through the electronic system's enforcement edits. In order to make a payment claim against an authorization, qualified providers must have an authorization number. In addition to this protection, the payment system prevents payment of claims greater than the payment authorization.

The record review is the same review described in Appendix H b.i.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Upon completion of each record review, the case manager is expected to make necessary corrections. Corrections are verified by either the QA unit or the case management supervisor. Reports and aggregate data are reviewed at all levels by individuals that make decisions on what improvements are needed individually or systemically. Regions and AAAs are required to develop corrective action plans to address any area where proficiency was less than 100%. Draft plans are reviewed by ADSA prior to approval and implementation. Progress reports are produced every six months. Statewide systemic issues are addressed in on-going case management training, policy review/revision/development, and other areas as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and A	nalysis (including trend identification)
Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
▼ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	▽ Quarterly
Other Specify:	☐ Annually
	Continuously and Ongoing
	Other Specify: 18 months

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

N	0
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Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Personal Care rate determinations are the responsibility of DSHS/ADSA and based on appropriations of the Washington State Legislature. Rates are negotiated between the union representing home care workers and the Governor's office. Legislative approval and appropriation is required following agreement between the parties.

ADSA uses the CARE tool, an automated system to collect demographic data, assess functional needs and abilities, health, and medical information, determine eligibility for services, develop a care plan, and authorize services for clients receiving or requesting long-term care services.

The CARE program evaluates information about the client based on major predicators of direct care need: clinical complexity, cognitive impairment, behavioral support needs and activities and incidental activities of daily living. ADSA, through CARE, employs a client classification methodology consisting of seventeen care groups. CARE uses algorithms to place clients in a classification group based on the assessment and assigns base hours.

The base hours are adjusted to account for informal support, paid by individual(s) or group(s) other than ADSA and support provided in shared living circumstances. CARE determines the adjustment by placing a numeric value on the amount of assistance available to meet the client's needs and reduces the base hours assigned to the classification group using assigned values for each specific ADL and IADL.

The rate determination process is established in the Washington Administrative Code (WAC) that contains the rules and regulation used to determine eligibility and payment rates. ADSA followed the Administrative Procedure Act (APA) RCW 34.05, inclusive of established mechanisms for public comment and input on the rates process, when adopting the new regulation contained in chapter 388-72A WAC, Comprehensive Assessment and Reporting Evaluation Tool.

For waiver services other than personal care, AAAs negotiate rates within ranges published by ADSA for each service. Payment cannot exceed 1)the prevailing charges in the locality for comparable services under comparable circumstances, or 2) the rates charged by the AAA for comparable services funded by other sources. The AAA must have written procedures for determining rates that are reasonable and consistent with market rates. Acceptable methods for determining reasonable rates include periodic market surveys, cost analysis and price comparison.

While the AAAs negotiate rates for waiver services other than personal care, there are standardized ranges that AAAs must adhere to for each service type. This allows AAAs to negotiate rates based upon the local market environment, but also ensures that rates fall within a standard range and are comparable across the state. In addition, waiver service definitions and contractor qualifications are all standardized. This too helps to ensure that rates are comparable across the state as AAAs are negotiating rates for identical services with providers that meet the same qualifications.

AAAs are contractually obligated to adhere to the AAA Policy and Procedure manual, which includes ADSA polices related contracting for waiver services. AAA contracting procedures are included in the risk assessment that is used to develop our ongoing monitoring of AAAs. ADSA's monitoring of AAA contracting procedures includes ensuring that AAAs maintain written procedures that are in accordance with state policy.

AAAs are all required to follow to the same policy related to the development and negotiation of rates. The policy sets standardized parameters for acceptable methods for determining reasonable rates. While there may be slight variations in each AAAs procedures, the procedure cannot deviate from the acceptable methods in the state's policy and rate ranges are standardized thus ensuring that rates are comparable.

AAAs maintain a list of all contracted service providers for each service type and the negotiated rates. Clients are provided with a list or choice of all available providers and the selection of the provider is based upon client choice

- and preference. The specific rate information is provided upon request, but the emphasis is placed on informing clients of their options and respecting client choice.
- **b.** Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Washington utilizes two systems to process claims pertaining to the services provided to waiver recipients. State plan services are processed through the Medicaid Management Information System (MMIS) and waiver services are processed through the Social Service Payment System (SSPS).

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

Aging and Disability Services Administration (ADSA) social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for applicant/recipients meeting financial and service eligibility factors using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient's case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service Authorization form (DSHS 14-159) after the first authorization is processed. ADSA and the Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment of authorized waiver services, which have been provided. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless ADSA or Area Agency on Aging direct service or contracted case manager staff re-authorize payment. The provider signs the invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):
 - No. State or local government agencies do not certify expenditures for waiver services.
 - **Second Second S**

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

▼ Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

- (a) the non-State public agencies that incur certified public expenditures for waiver services; County and municipal governments
- (b) how it is assured that the CPE is based on total computable costs for waiver services;

CPEs are only for administrative activities. No CPEs are based on expenditures for waiver services. The administrative rate is standardized and CPEs cannot exceed the standard rate.

(c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).

The state requires certification per 42 CFR 433.51(b) by the public agency that funds represent expenditures eligible for FFP.(Accounting Policy Management Board Policy #50.02 issued March 4, 2005)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The process for validating provider billings is as follows:

- (a) The individual was eligible for Medicaid waiver payment on the date of service;
- Aging and Disability Services Administration social workers, community nurse consultants and Area Agency on Aging direct service and contracted case manager will authorize waiver program services (as listed on the individual service plan) effective on the date all the following program factors constituting Medicaid eligibility for waiver services are satisfied:
- (1) Categorical relatedness and financial eligibility are approved.
- (2) The assessed applicant/recipient is eligible for nursing facility level care and is, or likely to be, institutionalized.
- (3) The individual service plan is developed and approved by the Aging and Adult Services Administration social worker, community nurse consultant or the Area Agency on Aging direct service or contracted case manager.
- (4) The recipient has approved the service plan.
- (5) The provider is qualified for payment.
- (6) The provider contract procedures are completed.
- (b) The service was included in the participant's approved service plan;

The waiver services in the approved plans are not authorized until steps in the description of the mechanism for assuring payments are made only for eligible service recipients are completed. Claims for payments can be made only after Aging and Disability Services Administration staff or Area Agency on Aging direct service or contracted case managers have authorized the payment on the Social Service Payment System (SSPS) database. The only services authorized are those services listed in the client's plan of care.

- (c) Verification that the services were provided:
- 1. Verification is obtained during face to face annual and significant change reviews with the recipient/legal representative.
- 2. Verification is obtained via quality management record reviews which may include face to face contact.
- 3. Verification may be obtained through the ADSA client grievance process The policy and procedure for this process was updated and disseminated in 2005 (MB H05-018 Policy/Procedure)

If billing problems are identified via the client, the QA process or the grievance process ADSA corrects the payment and adjusts the claim for FFP accordingly.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims

(including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a.	Method of	payments	MMIS	(select one):
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- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
- Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Washington uses two systems to process claims pertaining to the services provided to waiver recipients. State plan services are processed through the Medicaid Management Information System (MMIS) and waiver services are processed through the Social Service Payment System (SSPS).

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

Aging and Disability Services Administration (ADSA) social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for applicant/recipients meeting financial and service eligibility factors using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient's case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service Authorization form (DSHS 14-159) after the first authorization is processed. ADSA and the Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment of authorized waiver services, which have been provided. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless ADSA or Area Agency on Aging direct service or contracted case manager staff re-authorize payment. The provider signs the invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

• Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

1				

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- **b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):
 - The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
 - The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
 - The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Providers are paid only for services included in the State's contract with the Managed Care Entity.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*
 - No. The State does not make supplemental or enhanced payments for waiver services.
 - Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- **d.** Payments to State or Local Government Providers. Specify whether State or local government providers receive payment for the provision of waiver services.
 - **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
 - Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e*.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

D	escribe	the	recoupment process:
$\boldsymbol{\nu}$	CSCITUC	uic	recoupline process.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

- **f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*
 - © Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
 - Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the

State.			

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

- i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:
 - No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
 - Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

- ii. Organized Health Care Delivery System. Select one:
 - No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
 - Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

The Department contracts with Molina Healthcare of Washington, Inc. (Molina) to pilot a managed care

- project in Snohomish County called Washington Medicaid Integration Partnership (WMIP). Molina provides medical, chemical dependency, mental health, and long-term care services to eligible medical assistance clients through its provider network. All waiver long-term care services are available through WMIP as part of the benefit package. Participation in WMIP is voluntary. Prospective premium payments are paid to Molina through the MMIS.
- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- **a.** State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. Select at least one:
 - Appropriation of State Tax Revenues to the State Medicaid agency
 - Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of	f Fund	ls.
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Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- **b.** Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:
 - Not Applicable. There are no local government level sources of funds utilized as the non-federal share.
 - Applicable

Check each that applies:

■ Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by

local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

- (a) the local entity or entities that have the authority to levy taxes or other revenues; County and Municipal Governments
- (b) the source(s) of revenue; and, County and Municipal general fund
- (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:

Funds are directly expended as CPEs

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:
 - None of the specified sources of funds contribute to the non-federal share of computable waiver costs
 - The following source(s) are used

Check each that applies:

- **■** Health care-related taxes or fees
- **■** Provider-related donations
- Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings. Select one:
 - No services under this waiver are furnished in residential settings other than the private residence of the individual.
 - As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Clients living in residential facilities (Adult Family Homes & Boarding Home Facilities) are required to pay for their room and board at a rate set by the State. For clients with insufficient income to meet their room and board obligations, state funding is used to supplement client payments up to the room and board standard amount.

Payments for clients are authorized on a DSHS form 14-154/14-159 electronically through CARE The authorization includes the total cost of care for the individual for each month. This form includes an amount for client participation paid toward the cost of room and board.

When the SSPS system processes provider payments, any room and board costs listed on the SSPS form that are the responsibility of the client to pay to the provider are subtracted from the total amount owed for the month billed.

When the State submits for FFP, the amount billed is the actual amount paid by the State as reported by the SSPS payment system for the client's care in a residential setting.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- **a.** Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*
 - No. The State does not impose a co-payment or similar charge upon participants for waiver services.
 - Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.
 - i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that

applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

Nominal deductible

Coinsurance
Co-Payment
Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.
 - ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.
 - iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.
 - iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of

5)

- **b.** Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:
 - No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
 - Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	13763.80	8874.00	22637.80	31371.00	6886.00	38257.00	15619.20
2	14215.81	9761.00	23976.81	32939.00	7575.00	40514.00	16537.19
3	14706.81	10737.00	25443.81	34586.00	8332.00	42918.00	17474.19
4	15243.24	11811.00	27054.24	36316.00	9165.00	45481.00	18426.76
5	15833.15	12992.00	28825.15	38131.00	10082.00	48213.00	19387.85

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable) Level of Care: Nursing Facility
Year 1	32488	32488

Year 2	32943	32943
Year 3	33404	33404
Year 4 (renewal only)	33872	33872
Year 5 (renewal only)	34346	34346

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average length of stay was computed by summing the total days of personal care, enhanced adult residential care, assisted living, adult famnily home and managed care & divide by number of unduplicated clients.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- **c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
 - i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D:

A. Cost

2% increase per year for personal care enhanced adult residential care, assisted living and adult family home, and 1% increase for the remaining service categories.

B. Population

average 3.7% increase for personal care, average 1% increase for enhanced adult residential care, average 3.8% increase for adult family home. average 17.7% increase for managed care and average 1.2% decrease for assisted living.

Personal Emergency Response 2.9% increase,

Environmental Accessability Adaptations 33% increase,

Skilled Nursing 33% increase,

Transportation 1% increase,

Adult Day Care 4.2% increase,

Caregiver/Recipient Training 43% increase,

Home Delivered Meals 7% increase,

Specialized Medical Equipment & Supplies 13.7% increase,

In-Home Nurse Delegation 28.3% increase,

Community Transition Services 0.5% increase

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is calculated by applying a 10 % growth in medical expenses (based on historical data) to the data from the most recent CMS 372 report for each waiver year.

The base data for the projection of Factor D' are expenditures for services provided from 4/1/06 - 3/31/07. Medicare Part D was implemented 1/1/06, and dual eligibles were automatically enrolled in

- Medicare Part D. Expenditures for prescription drugs covered under Medicare Part D therefore are not in the base data, so there was no need to remove such costs.
- **iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:
 - Factor G is calculated by applying a 5% growth in nursing facility services costs to the data from the most recent CMS 372 report for each waiver year.
- iv. Factor G' Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is calculated by applying a 10 % growth in medical expenses (based on historical data) to the most recent CMS 372 report for each waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services						
Nurse Delegation						
Skilled Nursing						
Adult Day Care						
Caregiver/Recipient Training Services						
Home Health Aide						
Personal Care						
Community Transition Services						
Transportation						
Personal Emergency Response						
Home Delivered Meals						
Environmental Accessibility Adaptations						
Managed Care Option - Capitated						
Specialized Medical Equipment and Supplies						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Delegation Total:						109756.08

Nurse Delegation	Each	366	36.00	8.33	109756.08	
Skilled Nursing Total:	,					877567.20
						077007120
Skilled Nursing	Visit	471	34.00	54.80	877567.20	
Adult Day Care Total:						328333.50
Adult Day Care	Day	135	201.00	12.10	328333.50	
Caregiver/Recipient Training Services Total:						776220.48
Caregiver/Recipient Training Services	Hour	1251	8.00	77.56	776220.48	
Home Health Aide Total:						4095.30
Home Health Aide	Visit	2	365.00	5.61	4095.30	
Personal Care Total:						433305067.08
Adult Family Home	Day	4899	233.00	47.11	53774510.37	
Assisted Living	Day	5809	255.00	42.17	62466210.15	
Enhanced Adult Residential Care	Day	1828	234.00	48.28	20651866.56	
Personal Care	Day	23660	270.00	46.40	296412480.00	
Community Transition Services Total:		,	,	,		138164.52
Community Transition Services	Each	372	1.00	371.41	138164.52	
Transportation Total:						17046.54
Transportation	Trip	63	326.00	0.83	17046.54	
Personal Emergency Response Total:						2605815.03
Personal Emergency Response	Day	8447	273.00	1.13	2605815.03	
Home Delivered Meals Total:						1172414.88
Home Delivered Meals	Meal	1167	156.00	6.44	1172414.88	
Environmental Accessibility Adaptations Total:						2045182.90
Environmental Accessibility Adaptations	Job	1201	1.00	1702.90	2045182.90	
Managed Care Option - Capitated Total:						2522875.68
Managed Care Option - Capitated	Month	117	12.00	1796.92	2522875.68	
Specialized Medical Equipment and Supplies Total:						3255769.20
Specialized Medical Equipment and Supplies	Item	4170	2.00	390.38	3255769.20	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants):						
	Avo	erage Length of Stay on th	e Waiver:			

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J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Delegation Total:						141994.44
Nurse Delegation	Each	469	36.00	8.41	141994.44	
Skilled Nursing Total:						1177856.56
Skilled Nursing	Visit	626	34.00	55.34	1177856.56	
Adult Day Care Total:						344152.20
Adult Day Care	Day	140	201.00	12.23	344152.20	
Caregiver/Recipient Training Services Total:						1121202.08
Caregiver/Recipient Training Services	Hour	1789	8.00	78.34	1121202.08	
Home Health Aide Total:						4139.10
Home Health Aide	Visit	2	365.00	5.67	4139.10	
Personal Care Total:						451989777.20
Adult Family Home	Day	5075	233.00	48.05	56817923.75	
Assisted Living	Day	5737	255.00	43.01	62920834.35	
Enhanced Adult Residential Care	Day	1827	234.00	49.25	21055261.50	
Personal Care	Day	24388	270.00	47.26	311195757.60	
Community Transition Services Total:						140302.36
Community Transition Services	Each	374	1.00	375.14	140302.36	
Transportation Total:						17525.76
Transportation	Trip	64	326.00	0.84	17525.76	
Personal Emergency Response Total:						2704190.58
Personal Emergency						

Response	Day	8689	273.00	1.14	2704190.58		
Home Delivered Meals Total:						1267418.88	
Home Delivered Meals	Meal	1248	156.00	6.51	1267418.88		
Environmental Accessibility Adaptations Total:						2746744.18	
Environmental Accessibility Adaptations	Job	1597	1.00	1719.94	2746744.18		
Managed Care Option - Capitated Total:						2918343.12	
Managed Care Option - Capitated	Month	134	12.00	1814.89	2918343.12		
Specialized Medical Equipment and Supplies Total:						3737869.20	
Specialized Medical Equipment and Supplies	Item	4740	2.00	394.29	3737869.20		
	GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Delegation Total:						184212.00
Nurse Delegation	Each	602	36.00	8.50	184212.00	
Skilled Nursing Total:						1581299.20
Skilled Nursing	Visit	832	34.00	55.90	1581299.20	
Adult Day Care Total:						362423.10
Adult Day Care	Day	146	201.00	12.35	362423.10	
Caregiver/Recipient Training Services Total:						1619111.68
Caregiver/Recipient Training Services	Hour	2558	8.00	79.12	1619111.68	
Home Health Aide Total:						4175.60

Day Day Day	5257 5666 1826	233.00	49.01	60031417.81	471851242.03	
Day	5666	255.00				
Day			13 97	1		
	1826		45.67	63384692.10		
Day	7	234.00	50.23	21462475.32		
	25156	270.00	48.14	326972656.80		
					142466.40	
Each	376	1.00	378.90	142466.40		
					18011.50	
Trip	65	326.00	0.85	18011.50		
					2805771.15	
Day	8937	273.00	1.15	2805771.15		
					1371377.28	
Meal	1336	156.00	6.58	1371377.28		
					3691422.50	
Job	2125	1.00	1737.14	3691422.50		
					3343446.72	
Month	152	12.00	1833.03	3343446.72		
					4291326.48	
Item	5388	2.00	398.23	4291326.48		
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants):						
	Each Trip Day Meal Job Month Item Total Es Factor D (Divisor	Each 376 Trip 65 Day 8937 Meal 1336 Job 2125 Month 152 Item 5388 GRAND Total Estimated Unduplicated Par Factor D (Divide total by number of part	Each 376 1.00 Trip 65 326.00 Day 8937 273.00 Meal 1336 156.00 Month 152 12.00 Item 5388 2.00 GRAND TOTAL: Total Estimated Unduplicated Participants:	Each 376 1.00 378.90	Each 376 1.00 378.90 142466.40 Trip 65 326.00 0.85 18011.50 Day 8937 273.00 1.15 2805771.15 Meal 1336 156.00 6.58 1371377.28 Job 2125 1.00 1737.14 3691422.50 Month 152 12.00 1833.03 3343446.72 Item 5388 2.00 398.23 4291326.48 GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants):	

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Delegation Total:					Cost	238455.36
Nurse Delegation	Each	772	36.00	8.58	238455.36	
Skilled Nursing Total:	,	1	30.00	0.00		2124665.10
	V:-:4	1107	24.00	56.45	2124665 10	2121003.10
Skilled Nursing	Visit	1107	34.00	56.45	2124665.10	
Adult Day Care Total:						381288.96
Adult Day Care	Day	152	201.00	12.48	381288.96	
Caregiver/Recipient Training Services Total:						2338486.24
Caregiver/Recipient Training Services	Hour	3658	8.00	79.91	2338486.24	
Home Health Aide Total:						4219.40
Home Health Aide	Visit	2	365.00	5.78	4219.40	
Personal Care Total:						492925102.58
Adult Family Home	Day	5446	233.00	49.99	63433210.82	
Assisted Living	Day	5596	255.00	44.75	63857355.00	
Enhanced Adult Residential Care	Day	1826	234.00	51.24	21894032.16	
Personal Care	Day	25966	270.00	49.03	343740504.60	
Community Transition Services Total:						144660.60
Community Transition Services	Each	378	1.00	382.70	144660.60	
Transportation Total:				,		18223.40
Transportation	Trip	65	326.00	0.86	18223.40	
Personal Emergency Response Total:		,	,	<u> </u>		2911239.24
Personal Emergency Response	Day	9193	273.00	1.16	2911239.24	
Home Delivered Meals Total:		,		,		1482444.60
Home Delivered Meals	Meal	1429	156.00	6.65	1482444.60	
Environmental Accessibility Adaptations Total:						4958273.52
Environmental Accessibility Adaptations	Job	2826	1.00	1754.52	4958273.52	
Managed Care Option - Capitated Total:				,		3865639.68
Managed Care Option - Capitated	Month	174	12.00	1851.36	3865639.68	
Specialized Medical Equipment and Supplies Total:						4926390.56
Specialized Medical Equipment and Supplies	Item	6124	2.00	402.22	4926390.56	

GRAND TOTAL: 516319089.24
Total Estimated Unduplicated Participants: 33872
Factor D (Divide total by number of participants): 15243.24

Average Length of Stay on the Waiver: 282

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 (renewal only)

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nurse Delegation Total:						308954.16
Nurse Delegation	Each	991	36.00	8.66	308954.16	
Skilled Nursing Total:						2853736.96
Skilled Nursing	Visit	1472	34.00	57.02	2853736.96	
Adult Day Care Total:						403002.99
Adult Day Care	Day	159	201.00	12.61	403002.99	
Caregiver/Recipient Training Services Total:						3377133.60
Caregiver/Recipient Training Services	Hour	5231	8.00	80.70	3377133.60	
Home Health Aide Total:						4263.20
Home Health Aide	Visit	2	365.00	5.84	4263.20	
Personal Care Total:						515312276.77
Adult Family Home	Day	5641	233.00	50.99	67018859.47	
Assisted Living	Day	5526	255.00	45.65	64326784.50	
Enhanced Adult Residential Care	Day	1825	234.00	52.26	22317633.00	
Personal Care	Day	26821	270.00	49.94	361648999.80	
Community Transition Services Total:						146881.40
Community Transition Services	Each	380	1.00	386.53	146881.40	
Transportation Total:						18718.92
Transportation	Trip	66	326.00	0.87	18718.92	
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Personal Emergency Response Total:						3020340.96
Personal Emergency Response	Day	9456	273.00	1.17	3020340.96	
Home Delivered Meals Total:						1602881.28
Home Delivered Meals	Meal	1529	156.00	6.72	1602881.28	
Environmental Accessibility Adaptations Total:						6659439.06
Environmental Accessibility Adaptations	Job	3758	1.00	1772.07	6659439.06	
Managed Care Option - Capitated Total:						4442811.12
Managed Care Option - Capitated	Month	198	12.00	1869.87	4442811.12	
Specialized Medical Equipment and Supplies Total:						5654860.80
Specialized Medical Equipment and Supplies	Item	6960	2.00	406.24	5654860.80	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						